Michigan Department of Community Health

MDCH

Jennifer M. Granholm, Governor
Janet Olszewski, Director

MICHIGAN Department of Education

REQUESTS FOR PROPOSALS
for
SCHOOL-BASED AND SCHOOL-LINKED CHILD AND ADOLESCENT HEALTH CENTERS & PLANNING GRANTS

***Issued Collaboratively By*:**

Michigan Department of Community Health
&
Michigan Department of Education

<u>Proposals Due by December 17, 2008</u>

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH AND
MICHIGAN DEPARTMENT OF EDUCATION
October 31, 2008

ANNOUNCEMENT FOR REQUESTS FOR PROPOSALS FOR SCHOOL-BASED OR SCHOOL-LINKED CHILD AND ADOLESCENT HEALTH CENTER FUNDING

This packet includes:

- Grant Announcement
- Part I: General Information
- Part II: Additional Information
- Part III: Review Process and Information
- Part IV: Application Information, Instructions, and Review Criteria for Clinical Planning Grants
- Part V: Application Information, Instructions, and Review Criteria for Clinical SB/SL-CAHCs and Alternative Clinical CAHCs.
- Attachments

NATURE OF ACTION REQUESTED: _____X_____VOLUNTARY

The Michigan Departments' of Community Health and Education are pleased to announce the availability of funding for School-Based and School-Linked Child and Adolescent Health Centers (SBSL-CAHC), including planning grants to start new centers. Approximately **$2,440,000** is available for funding both School-Based and School-Linked Child & Adolescent Health Centers, Alternative Clinical Health Centers and for planning grants to start new Clinical or Alternative Clinical Centers. The grants will be awarded through a competitive process.

The grant application for Child & Adolescent Health Centers including all required forms is available on the Child and Adolescent Health Center website (www.michigan.gov/cahc) and the Coordinated School Health and Safety Program website (www.michigan.gov/cshsp). Completed applications must arrive on or before December 17, 2008. **An ORIGINAL and FOUR (4) copies (for a total of five) of the completed application must be submitted at that time.**

An informational meeting will be held on November 17, 10:00 AM-12:00 PM, **for planning grants only**. The meeting will be held at the Okemos Conference Center in Okemos, MI, and will include more detailed information about the Child and Adolescent Health Center Program. Directions can be found at http://www.okemosconferencecenter.com/. **To RSVP for the informational meeting e-mail Taggert Doll, Child and Adolescent Health Center Program Coordinator, at dollt@michigan.gov.**

The application and a *Frequently Asked Questions* webpage will be available November 10 through November 21, 2008 for public use throughout the application-writing period at

www.michigan.gov/cahc. The application, related forms, and frequently asked questions can be found at that site. Any questions regarding the application **must** be submitted to Taggert Doll, Child and Adolescent Health Center Program Coordinator at dollt@michigan.gov. Questions will be responded to and posted solely using this webpage. The questions and responses will be available for public access within two business days of receipt of the original question. It is up to each applicant to regularly check the *FAQ* webpage. Questions regarding the Child and Adolescent Health Center grant application process may also be directed to Taggert Doll.

The website is the only opportunity that grantees will have to ask questions regarding the *Clinical and Alternative Clinical* proposals.

The webpage and informational meeting are the only opportunities that grantees will have to ask questions regarding the *Planning Grants*.

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MICHIGAN DEPARTMENTS OF COMMUNITY HEALTH AND EDUCATION
OCTOBER 31, 2008

APPLICATIONS FOR CHILD & ADOLESCENT HEALTH CENTERS

PART I: GENERAL INFORMATION

INTRODUCTION:

The Michigan Departments' of Community Health and Education are pleased to announce the availability of $2,440,000 in funds for new Child & Adolescent Health Centers (CAHC). Section 31a, Subsection 6 of the State School Aid Act of 2008-2009 (*Attachment A*) provides state funding for Child and Adolescent Health Centers. Federal Medicaid Outreach dollars are leveraged with this state funding.

School-based and school-linked health center services have been provided in Michigan since the 1980's. State funding for such services began in 1987 through the Michigan Department of Public Health (now the Michigan Department of Community Health) and were focused exclusively on the adolescent population. Leveraged federal funding in 2004 allowed for the expansion of clinical services to the elementary age population (youth 5-10). The CAHC program is jointly managed by the Michigan Department of Community Health and Michigan Department of Education.

For the purpose of this application guidance, school-based health centers are primary care centers that are LOCATED ON SCHOOL PROPERTY. School-linked health centers are primary care centers that have strong ties to surrounding schools or school districts but are NOT LOCATED ON SCHOOL PROPERTY. Centers operating on school property must follow School Code regulations.

Alternative Clinical Health Centers are LOCATED ON SCHOOL PROPERTY only.

Many children and adolescents in Michigan communities confront serious health concerns: unintentional injuries; child abuse and other interpersonal violence; alcohol, tobacco and other drug use; overweight and obesity; early pregnancy and childbearing; family conflict; depression and teen suicide. These problems have a direct, negative impact on school attendance, academic achievement and school completion. Many children and adolescents in Michigan lack adequate access to the health services needed to prevent and intervene in these health problems. A major emphasis of this program is to ensure that eligible children and adolescents within or linked to targeted schools are insured and have access to preventive services such as Early, Periodic, Screening, Diagnosis and Treatment (EPSDT). Increasingly, families cannot afford time away from school and work to seek needed health services. Many live in areas with limited healthcare providers, and lack health insurance, money, transportation and knowledge of how to use local health care systems.

The period of adolescent growth and development is filled with risks and opportunities. These years mark the formation of health behavior patterns that have lifelong ramifications. Most young people, ages 10-21, growing up in the United States have the potential of maturing into

responsible, healthy adults. However, certain groups of young people are limited because of their health status, the economic condition of their families/communities, and their involvement in many high-risk behaviors, which include: school drop-out; use of alcohol, tobacco or other drugs; unsafe driving; early and/or unprotected sexual activity; fathering a child or becoming pregnant; poor nutrition; lack of exercise; and involvement in violent behavior. Adolescence is a time of change physically, emotionally and cognitively. While risk-taking behaviors are normal in the movement through this life cycle, adult and health-related intervention is often necessary to assure that these youth emerge safe and healthy. In the United States, the adolescent population is the least likely age group to receive needed and appropriate health care services. Adolescent-specific school-based and school-linked health center models are designed to address this unmet need and provide services unique to the adolescent population in a "teen friendly" environment.

The Departments embrace the notion that "healthy kids learn better". Moving primary care services into or close to schools with significant numbers of uninsured and underinsured children and families that have problems accessing adequate health services, gives children and adolescents access to care in an environment that is tailored to their unique needs and conveniently located. Through the establishment of SBSL-CAHC services, interventions can be provided to the five to 21-year-old population with the aim of achieving the best possible physical, intellectual, and emotional health status. Funding of these programs, and ensuring on-going support for program growth that meets the needs of the community and the target population, requires collaboration with the state, local community organizations, parents and schools.

Services offered by Clinical and Alternative Clinical Health Centers must include at a minimum: 1) comprehensive primary medical care including preventive services, 2) chronic disease management, 3) Medicaid outreach and enrollment, 4) access to Medicaid preventive services, 5) early intervention and other support services including psychosocial services, 6) health education and promotion; and 7) referral services.

For a list of key terms and definitions for this competitive process, please refer to Attachment B.

MDCH and MDE embrace the CAHC model as an effective means for increasing access to basic health care for children and teens in under-served communities. There is a growing body of evidence that access to primary health care in schools can improve health status and learning readiness. **With this RFP, the Departments are seeking applications for:**

1. School Based and/or School Linked Clinical Child and Adolescent Health Centers.
2. School Based Alternative Clinical Child and Adolescent Health Centers.
3. Planning grants to determine the feasibility of starting new Clinical or Alternative Clinical Child and Adolescent Health Centers.

GRANT PURPOSE

A major role of the CAHC model is to provide a safe and caring place for children and adolescents to learn positive health behaviors, prevent diseases, and receive needed medical care

and support, thereby resulting in healthy youth who are ready and able to learn and become educated, productive adults. CAHCs assist eligible children and youth with enrollment in Medicaid and provide access to Medicaid preventive services. CAHCs are required to collaborate with Medicaid Health Plans as necessary to ensure that children and youth are receiving needed health services. It is crucial to have community acceptance and support for these child and adolescent health service models.

This request seeks competitive proposals for planning the delivery of health services to the five to 21-year-old population in geographic areas where it can be documented that health care services accessible and acceptable to children and youth **require enhancement or do not currently exist**. The services should aim at achieving the best possible physical, intellectual, and emotional status for the target population. The infants and small children of the adolescent population may also be served, where appropriate.

These grant application instructions are provided to interested and eligible parties to enable them to prepare and submit competitive proposals for the following:

1. **Planning Grants** – designed to provide support to communities interested in convening a planning process to determine the feasibility and community support for implementing a new clinical CAHC. During the planning process, communities will provide a limited number of Medicaid outreach activities to eligible children and youth in their service area. It is anticipated that approximately six of the nine planning grants will receive funding to move forward as full Clinical or Alternative Clinical centers after the initial 6 month planning period. To be considered eligible for funding, **planning grants must be submitted for school districts that do not currently have a Clinical Child and Adolescent Health Center. School districts with current Clinical Child and Adolescent Health Centers are not eligible for planning grants.**

2. **Clinical Child & Adolescent Health Center Grants**– designed to provide primary care (including well care and diagnosis and treatment for both acute and chronic illness), psychosocial and health promotion/disease prevention services, Medicaid outreach activities and access to Medicaid preventive services in a "consumer" friendly manner and atmosphere to eligible children and youth. Clinical centers are required to be open a minimum of 30 hours, 5 days a week and serve a minimum of 500 unduplicated youth for adolescent sites, 350 unduplicated children for elementary sites.

3. **Alternative Clinical Health Center Grants** – designed to provide primary care (including well care and diagnosis and treatment for both acute and chronic illness), psychosocial and health promotion/disease prevention services, Medicaid outreach activities and access to Medicaid preventive services in a "consumer" friendly manner and atmosphere to eligible children and youth. Alternative Clinical Health Centers (ACHC) differ from Clinical centers only in the number of hours they are required to be open and the number of youth required to be reached. ACHCs are required to be open a minimum of 24 hours, 3 days a week and serve a minimum of 200 unduplicated youth. ACHCs MUST be school-based.

Communities applying for Clinical or Alternative Clinical sites MUST be operational including the ability to meet the State's minimum program requirements within 120 days of the start of the contract. Follow the instructions outlined in Part V of this guidance for Clinical and Alternative Clinical Health Centers.

ELIGIBLE APPLICANTS

Eligible applicants include public and non-profit entities (e.g., local health departments, community health centers, Federally Qualified Health Centers, non-profit hospitals/health systems, school districts and other health care or social service organizations qualified to provide school-based or school-linked health care services). Documentation of incorporation as a non-profit agency or other legal status or evidence of application must be included with this application. Applicants must demonstrate collaboration between the local school district and health care providers in the proposal. Agencies proposing services in school districts with current Clinical Child and Adolescent Health Centers are not eligible for planning grants.

ASSURANCES

To be eligible for funding, all applicants must provide written assurance that abortion services, counseling and referrals for abortion services will not be provided as part of the services offered. For programs providing services on school property, written assurance will be required that family planning drugs and/or devices will not be prescribed, dispensed or otherwise distributed on school property as mandated in Michigan School Code. Proposals must include a statement of assurance of compliance with all federal and state laws and regulations prohibiting discrimination and with all requirements and regulations of the Michigan Department of Education and Michigan Department of Community Health. **These assurances must be included in the application cover letter.**

TARGET POPULATIONS TO BE SERVED

This request seeks proposals for the delivery of health services or for planning the delivery of health services to the 5-21 year old population in geographic areas where it can be documented that health care services accessible and acceptable to children and youth require enhancement or do not currently exist. The infants and small children of the adolescent target population may also be served where appropriate.

FUNDING LIMIT AND DURATION OF FUNDING

This grant will provide base funding for Clinical Health Centers, Alternative Clinical Health Centers and planning grants. Funding recommendations for Child and Adolescent Health Centers suggest for program sustainability, a formula exist with equal partnership between state, school/local and community. The formula Michigan is working to maintain is derived from this national model of 1/3 state, 1/3 school/local and 1/3 community support. The intent of this grant is to provide funding for the state contribution of the recommended formula.

Base grants (Clinical, Alternative Clinical, Planning) will vary due to unique differences in program operations, e.g., cost-based reimbursements and types of services provided.

- **Planning Grants** – up to 9 planning grants will be available[1].
  - ✓ Planning Grants will receive up to **$50,000** to conduct local planning to determine the feasibility, community commitment and documented need for implementing a new Clinical or Alternative Clinical health center. **If, at the end of the planning process, the community is invited to continue forward with implementing a Clinical or Alternative Clinical health center, the grantees will receive base funding of:**
    - Clinical Health Centers: $175,000 or $225,000 annually (see below for funding details).
    - Alternative Clinical Health Centers: $120,000 (school-based only)

  Approximately 6 of the 9 planning grants will be invited to move forward with developing an operational health center.

- **Clinical Child & Adolescent Health Centers** – 4 to 6 awards will be available[1].
  - ✓ School-Based Health Centers, which are located on school property, will receive base funding of **$175,000** per year.
  - ✓ Community-Based or School-Linked centers will receive base funding of **$225,000** per year.
  - ✓ Federally Qualified Health Centers (FQHC) that are Community-Based/School-Linked or School-Based will be eligible for the **$175,000** base funding allocation due to their unique ability to secure full cost-based reimbursement for services.

- **Alternative Clinical Health Centers** – 2 awards will be available.
  - ✓ ACHCs must be located on school property.
  - ✓ ACHCs will receive **$120,000** per year.

START DATE OF FUNDING

Clinical and Alternative Clinical Health Center awards will begin April 1, 2009 and end September 30, 2015.

Planning grantees will begin the planning process on April 1, 2009 and end September 30, 2009. For communities that are invited to move forward with initiating a new Clinical or Alternative Clinical CAHC, the grant cycle will begin October 1, 2009 and end September 30, 2015. Implementation of full services will vary depending on community readiness with the expectation that all planning grant centers are fully operational by April 1, 2010. Funding is available to support up to 9 planning communities with approximately 6 of those invited to continue forward with implementing a Clinical or Alternative Clinical Health Center.

Annual non-competitive applications will be due for all funded grantees in future years through September 30, 2015. Awards are contingent upon the availability of funds as well as the performance of the grantee in previous years. MDCH and MDE reserve the right to terminate

[1] Numbers of awards are subject to change based on number of applications received.

any contract due to failure to meet established minimum program and reporting requirements and/or failure to meet annual negotiated performance numbers.

Neither MDCH nor MDE are liable for any costs incurred by applicants prior to the execution of a contract. **A local match of 30 percent of the amount requested is required.** Any match provided by a collaborative partner must be documented in writing by that organization and included as part of this proposal. **If one organization is applying for more than one grant in different geographic locations or more than one model of funding, separate applications and budgets must be submitted.**

REJECTION OF PROPOSALS
MDE and MDCH reserve the right to reject any and all proposals received as a result of this announcement and will do so if the proposal does not adhere to funding specifications, or preparation instructions.

CLOSING DATE AND DELIVERY ADDRESS
Proposals are due on or before 5:00 p.m., Wednesday, December 17, 2008. If a proposal arrives after this due date or is submitted by fax or e-mail, it will not be considered or reviewed. Proposals submitted, but not in accordance with the proposal preparation instructions (below), will not be accepted and will be returned to the applicant *without review*.

The ORIGINAL proposal, bearing ORIGINAL signatures and FOUR (4) COPIES (for a total of five) of the completed proposal must be documented by delivery agent for delivery on or before **Wednesday, December 17, 2008.** Proposals should be mailed via U.S. mail, U.P.S. or Federal Express or other similar courier in sufficient time as to arrive on or before the due date.

Proposals should be mailed to the attention of:

Michigan Department of Community Health
Child and Adolescent Health Center Program Coordinator
ATTN: Taggert Doll
109 Michigan Ave, 4th Floor
Lansing, MI 48913

You will receive a faxed confirmation of receipt of your proposal by the Michigan Department of Community Health within three business days of arrival at MDCH. **Complete Attachment D: Application Fax-Back Form and Checklist and include it as the cover page of your proposal**. If you do not receive this confirmation notice by fax within three days of submission of your proposal, please immediately call Taggert Doll, Child and Adolescent Health Center Program Coordinator at MDCH at (517) 335-9720.

Acceptable packaging and mailing procedures are:

- The postmark or other mailing validation must be documented by delivery agent for delivery **on or before December 17, 2008**. The original proposal and all required copies should be enclosed in a sealed envelope within the mailing packet. A completed checklist must be attached on the top of the inside envelope for appropriate check-in by the unit secretary. If the applicant used a delivery service, the dated receipt for delivery service must be available to validate the **December 17, 2008,** postmark requirement.

- When the proposal is received, the Application Fax-Back Form: Confirmation of Receipt on the front of the application package will be signed by the appropriate personnel and then faxed to the applicant to verify receipt of proposal and participation in the grant process. **The applicant is responsible for contacting Taggert Doll at (517) 335-9720 or dollt@michigan.gov by December 19, 2008 if the applicant does not receive a faxed copy of the signed form.**

- In case of late delivery of the proposal, verification of appropriate delivery efforts will be required to participate in this grant process.

The Departments will appoint an objective review committee to review and prioritize proposals for funding. Notification of award or rejection is expected by February 2009.

PROPOSAL PREPARATION, PAGE LIMIT AND FONT SIZE
Proposals should be prepared simply and economically, providing a concise description of the requirements of the proposal with a narrative no longer than 30 pages in length for Clinical and Alternative Clinical CAHCs and no longer than 10 pages in length for planning grants. Proposals should be typed with a font no smaller than Times 12 point font, double-spaced, single-sided, and using standard one-inch margins. Applicants must number all pages sequentially, including attachments.

Proposals should not be stapled together but rather sent in unbound. Individual binder clips should be used to bind each copy of the proposal(s). Special bindings and binders should not be used. Required forms and support documents (title page, table of contents, certifications and assurances, list of advisory council members, copies of policies and procedures, interagency agreements, budget forms, budget narrative, work plan, and letters of commitment/support and need) are not counted in the narrative page limit. Supplementary materials will not be reviewed and will be discarded.

ACKNOWLEDGEMENT
All publications, including: reports, films, brochures, and any project materials developed with funding from this program, must contain the following statement: "**These materials were developed with state funds allocated by the Michigan Department of Education and Michigan Department of Community Health."**

AMERICANS WITH DISABILITIES ACT

MDE and MDCH are committed to providing equal access to all persons in admission to, or operation of its programs or services. Individuals with disabilities needing accommodations for effective participation in this program are invited to contact either of the two State Departments for assistance.

AVAILABILITY OF APPLICATION

The application packet is available from the Child and Adolescent Health Center website at www.michigan.gov/cahc and the Coordinated School Health and Safety Program at www.michigan.gov/cshsp.

WHERE TO OBTAIN ASSISTANCE

MDCH and MDE issues the instructions contained in these materials, and are the sole points of contact in the State for this program.

A *Frequently Asked Questions* webpage will be available for public use November 10 through November 21, 2008 at www.michigan.gov/cahc. The application, related forms, and frequently asked questions can be found at this site. Any questions regarding the application **must** be submitted to Taggert Doll, Child and Adolescent Health Center Program Coordinator at dollt@michigan.gov. Questions will be responded to and posted solely using this webpage. The questions and responses will be available for public access within two business days of receipt of the original question. It is up to each applicant to regularly check the *FAQ* webpage. **The website is the only opportunity that grantees will have to ask questions regarding the Clinical and Alternative Clinical proposals.**

An informational meeting will be held on November 17, 10:00-12:00, **for planning grants only**. The meeting will be held at the Okemos Conference Center in Okemos, MI. Directions can be found at http://www.okemosconferencecenter.com/. **To RSVP for the information meeting e-mail Taggert Doll, Child and Adolescent Health Center Program Coordinator, at dollt@michigan.gov.**

The webpage and informational meeting are the only opportunities that grantees will have to ask questions regarding the planning grants.

PART II: ADDITIONAL INFORMATION

FUNDING PROCESS

The Departments will make the Clinical, Alternative Clinical and planning grants available through a competitive process for fiscal year 2009. Only those successful applicants receiving funding in FY 09 funding cycle that have satisfactory progress in achieving performance measures as evidenced by required progress and financial reporting will be invited to apply for continuation funding to operate a CAHC through the entire funding cycle (ending September 30, 2015).

PAYMENT SCHEDULE

Michigan Primary Care Association (MPCA) will issue contracts to all grantees on behalf of the two Departments. Grantees will receive quarterly payments from MPCA. Expenditures must be reported quarterly and year-end in accordance with the terms and conditions of this agreement and outlined in the CAHC contract issued by MPCA. Expenditures must be based on quarterly reports, records, and other requested documentation maintained by the grantee.

FINANCIAL REPORTING

Quarterly and year-end expenditure reports will be required of all grant recipients. The final expenditure report is due within 60 days of the end of the project year (by November 30, 2009). *All financial reporting requirements are detailed in Attachment E.*

PERFORMANCE REPORTING AND MONITORING RESPONSIBILITIES

After grants are awarded, the grantee will carry out the proposed programming under the general direction of MDCH and MDE. Program oversight, including technical assistance and consultation will be provided by MDCH. For Clinical and Alternative Clinical centers, the services and activities described in the Minimum Program Requirements, *Attachment C*, at a minimum must be addressed in the proposal and implemented throughout the funding cycle.

Quarterly and year-end reports will be required of all grant recipients including data and billing collection, financial reporting, and program objective outcomes. A final year-end narrative report must describe how well the agency met the goals, objectives and service/work plan outlined in the proposal. The reports are subject to be used by both MDE and MDCH to assist in evaluating the effectiveness of programs funded under the state grants program and to report to the legislature. All reporting requirements, with required due dates and information detailing where to send reports, are outlined in *Attachment E.*

TECHNOLOGY REQUIREMENTS

Each funded applicant is required to have an accessible electronic mail account (email) to facilitate ongoing communication between MDE, MDCH and grantees. All funded grantees will be added to the State-funded list serve, which is the primary vehicle for communication between the State Departments and grantees.

Applicants providing clinical services must have the necessary technology and equipment to support billing and reimbursement from third party payers. Minimum Program Requirements #18, #19, and #20 (*Attachment C*) for both elementary and adolescent health centers describe the billing and reimbursement requirements for all grantees.

TECHNICAL ASSISTANCE AFTER AWARD NOTIFICATION

After notice of award, each CAHC will receive a site visit from a representative of the technical assistance team from MDCH for an on-site orientation and review of program expectations. Within the first two years, each newly funded CAHC will have a comprehensive site review scheduled to ensure that all minimum program requirements are being met and to provide technical assistance to newly funded centers. After this initial site review, subsequent reviews will occur <u>at least</u> once every three years, or more frequently if deemed necessary.

Each successful planning grant applicant will receive a site visit from the technical assistance team from MDCH to assist in identifying areas of needed technical assistance. Once funded, successful planning grant applicants are required to work with the technical assistance team to give priority to and address areas of needed technical assistance and training including, but not limited to, administrative functions, governance, managed care/billing, financial management, data management and clinical management. Each planning community will be assigned a "*Community Consultant*" from the technical assistance team to be a central point of contact for their community as the planning process is convened. These *Community Consultants* will periodically attend Community Advisory Council meetings for their assigned planning communities and facilitate any requests for technical assistance.

PART III: REVIEW PROCESS AND INFORMATION

PROPOSAL REVIEW PROCESS AND APPROVAL

All proposals will be reviewed jointly by MDCH and MDE and evaluated using a peer review system. Proposals must address all of the identified criteria and contain all requested information in the format laid out in this guidance. Award selections will be based on merit and quality as determined by points awarded for the Review Criteria Section and all relevant information. Rubrics will be used as a rating instrument in the review process and can be obtained from either Carrie Tarry at TarryC@michigan.gov or Taggert Doll at dollt@michigan.gov. Each applicant will receive feedback including specific strengths, weaknesses, and recommendations based on their proposal. Successful applicants must respond to any conditions of funding within 30 days of receiving written notice of award. All funding will be subject to approval by the Superintendent of Public Instruction at the Michigan Department of Education and Director of the Michigan Department of Community Health.

ADDITIONAL REVIEW FACTORS

In addition to the review criteria in Part IV and Part V, MDE and MDCH may apply other factors in making funding decisions, such as: 1) geographical distribution; 2) gaps in services; 3) duplication of effort; 4) duplication of funding; 5) agency capacity; 6) evidence that an applicant has performed satisfactorily on previous projects; and 7) other factors relevant to addressing changing needs and populations.

GRANT REVIEWERS

MDE and MDCH will designate a panel of peer reviewers with extensive knowledge of the Child & Adolescent Health Center Program Requirements. The panel will consist of at least one representative from the Michigan Department of Community Health, Michigan Department of Education and Department of Human Services. There will also be at least one representative from a community partnership and one representative from an Intermediate School District or Local Education Agency. In addition, this review panel will receive training prior to reviewing proposals and will use a consensus process to enhance reviewer reliability of the final score. **Persons involved in the development of a proposal, associated with a district submitting a proposal, or having any other conflict of interest may not serve as reviewers.**

APPLICATION INSTRUCTIONS

- Application information, instructions and review criteria for the planning grants are detailed in Part IV of this application guidance.

- Application information, instructions and review criteria for Clinical and Alternative Clinical Child & Adolescent Health Center Grants are detailed in Part V of this application guidance.

If one organization is applying for more than one grant in different geographic locations or more than one model of funding, separate applications and budgets must be submitted.

PART IV: APPLICATION INFORMATION, INSTRUCTIONS, AND REVIEW CRITERIA FOR THE 2009 CAHC PLANNING GRANTS

Planning grants will be given a six-month planning phase that begins April 1, 2009 and ends September 30, 2009.

Support for funding for future years is contingent upon the availability of funds and successful program planning and readiness to implement programming. Training, technical assistance, and consultation during the planning phase will be provided by MDCH through the Adolescent and School Health Unit of the Division of Family and Community Health. MDE and MDCH will make final determinations on the number of planning communities that are selected to move forward in developing a clinical center. Funding is available to support up to 9 planning communities with approximately 6 invited to continue forward with implementing a Clinical or Alternative Clinical health center. **Planning grants are only for school districts that currently do not have a Clinical Child and Adolescent Health Center.**

PART A – COVER SHEET/APPLICATION (page 1 of the application)

The organization or agency submitting the proposal must be fully identified, as well as the direct contact person for this program. All boxes must be appropriately completed. The application requires an **original signature of the superintendent, director of the local education agency OR person with binding authority from the applicant agency**. Rubber stamps and copies are unacceptable.

Service Area. Complete the ***Service Area and Target Population Demographics Worksheet*** provided in *Attachment F*. This information is required. Proposals that do not have a completed worksheet included will not be reviewed.

Target Population. Identify the age group of the target population that will be served by the proposed project.

Children ages 5-10 (Elementary Age Population)

Youth ages 10-21 (Middle and High School Age Population and Young Adults)

A total of 248 points are available for applicants applying for planning grants.

PART B – ASSURANCES

To be eligible for funding, all applicants must provide written assurance that abortion services, counseling and referrals for abortion services will not be provided as part of the services offered. For programs providing services on school property, written assurance will be required that family planning drugs and/or devices will not be prescribed, dispensed or otherwise distributed on school property as mandated in Michigan School Code. **These assurances must be included in the application cover letter.**

PART C – GRANT PROGRAM DETAILS (248 points)

1. Title Page. Provide the name and address of the applicant agency, federal identification number, name and telephone number of the authorized agent of the applicant agency, project director/coordinator name, address, telephone number, fax number and email address, and the service/target area for which the proposal requests funds (school or school district, county, city, metropolitan area, etc.).

2. Table of Contents. Provide a table of contents with corresponding page numbers. Number each page of the proposal. Attachments should also be paginated and listed in the table of contents.

Proposal Narrative:

3. Preliminary Assessment of Needs/Assets among Your Community's Youth (60 points). Provide initial information on children or adolescent needs that will be addressed by a new Child and Adolescent Health Center. Complete the ***Need Statement Worksheet*** found in *Attachment G*. Provide a narrative description which incorporates, explains and expands upon this data. At a minimum, each applicant must provide a narrative explanation for four Barriers to Access and ten Health Disparity factors listed in the Need Statement Worksheet. Additional indicators of need that could be used to expand upon this data include, but are not limited to: federal designation as a Medically Underserved Area (MUA) and/or Medically Underserved Population (MUP); number enrolled and demographics of students attending the proposed school site/district; and local surveys depicting student needs/assets. Where possible, data should be as specific to the proposed geographic location of the CAHC as possible. Include recent data, identifying the year and source of all data. Describe community resources available to meet youth health care needs and how a new CAHC would be integrated with existing services and would fill gaps in current services.

Suggested resources for Michigan-specific data include:

- Michigan 2007 Youth Risk Behavior Survey, www.michigan.gov/yrbs
- Michigan Department of Community Health Statistics and Reports, www.michigan.gov/mdch
- Michigan Department of Education, www.michigan.gov/mde
- Michigan Profile for Health Youth www.michigan.gov/miphy
- Department of Human Services, www.michigan.gov/dhs
- Kids Count, www.kidscount.org
- Michigan Primary Care Association, http://www.mpca.net/healthpolicy/profiles.htm

National resources for School Based Health Centers include:

- National Assembly on School-Based Health Care: www.nasbhc.org
- George Washington University, *Center for Health and Health Care in Schools*: www.healthinschools.org

Include the completed Need Statement Worksheet (Attachment G) as an attachment immediately following the budget forms.

Provide a map of the proposed service area as an attachment immediately following the Need Statement Worksheet.

4. Capacity and Readiness of Sponsoring Agency and Community (40 points). Provide a brief history of the sponsoring agency, including the agency's mission statement. How is the proposed project compatible with the agency's mission? What major linkages with public and private organizations, health care agencies, and school systems has this agency established through other initiatives? What other major initiatives have this agency managed? Provide rationale as to why this agency is appropriate to coordinate the CAHC planning process.

5. Staffing Plan (10 Points). Provide a staffing plan, job description and, if available, the resume or vitae of staff assigned to coordinate the planning effort (those paid for by this grant, other funding sources and volunteers) noting existing staff as well as additional staffing needs. One individual must be designated as the program coordinator with sufficient authority, expertise and dedicated work time to carry out project activities.

6. Strength of Community Advisory Council (CAC) (20 points). Describe the extent to which key local partners involved, or proposed to be involved, in the CAC have had experience working together to improve the health of children and youth in the proposed area of need. Describe previous, existing or intended collaborative planning processes in the community that could be linked and coordinated with this planning effort. Describe any activities of the CAC in planning a CAHC thus far, if applicable.

An array of school and community health programs and systems delivering health care to children in Michigan have overlapping target populations, purposes and services, which may not be well coordinated. To this end, successful grantees must include at a minimum the following partners in their planning:

- Administrators and staff from the school building in which services are proposed, if planning a *school-based* Child & Adolescent Health Center;
- School health program representatives (*minimum of 2*) such as: Coordinated School Health representatives, health education teacher, school nurse, social worker, psychologist, counselor, and/or special education teacher;
- Medical service providers from the proposed provider agency;
- Parents
- Youth from the target population (if an adolescent site is being proposed); and
- Local public health department.

Consider including these additional representatives on your CAC: superintendent, school board members, building principals, school health coordinator, sex education supervisor, local community health, mental health, substance abuse, community collaborative bodies, and dental providers; faith-based organizations; Parent/Teacher Association or Organization (PTA/PTO), and other youth-serving agencies. Proposals are

further strengthened by support from broad community representatives who are actively involved in the planning process.

Provide an initial roster of proposed or existing CAC members as an attachment immediately following the map of the proposed service area.

7. Barriers/Assets of the Community (20 points). Identify any anticipated barriers that might arise during the planning process. How will these barriers be addressed during the planning process? Identify any unique assets that your community/school has that will aid in the planning process. How will these assets/strengths be capitalized on to strengthen planning in this community? Please note that applicants will not be penalized for listing barriers in their community. The identification of any anticipated or real barriers will help strengthen local planning efforts and will assist the Technical Assistance Team at MDCH in providing tailored technical assistance that will help address these barriers.

8. Work plan (40 points). This section is subdivided into two pertinent areas: *Required Goal and Objectives for Planning Grantees* and *Required Reports and Trainings for Planning Grantees:*

Each planning grant work plan will have the same goal and six required objectives, which are detailed below. These objectives have been based on the outcomes expected at the end of the planning period. **Applicants are encouraged to add additional objectives that are tailored to the community and reflect the community's progress in the planning process.** Additional objectives should be SMART (Specific, Measurable, Appropriate, Realistic and Time-phased) and be based on the steps the community/school needs to take to accomplish its projected outcomes.

Plans and activities for achieving all objectives should be fully integrated into the work plan. Within the work plan, proposed key activities should be fully and clearly described for the period **April 1, 2009, through September 30, 2009**. Each key activity must have a **documented and quantifiable outcome (process or product)**. The **source or method** of documentation of achievement of each key activity and outcome should be identified. The **projected date of completion** for each key activity and outcome should be clearly stated. The **person(s) responsible for completion** of each key activity should be identified.

Work plans *must* follow the format outlined in Attachment H.

Required Goal and Objectives for Planning Grantees:

Goal: By October 1, 2009, document the need and demonstrate the readiness and support of the community/school for instituting a clinical school-based or school-linked child and adolescent health center.

Objective 1: By May 1, a ***Community Advisory Council*** (CAC) will be formed or designated.

Objective 2: By June 30, a needs assessment of the health needs of the target population will be completed.

Objective 3: By July 30, services to be offered in the CAHC that are responsive to both the minimum program requirements and to the health needs of the target population will be identified.

Objective 4: By August 15, school system and/or sponsoring agency approval and in-kind support, as well as other community resources and funding support, will be committed and documented.

Objective 5: By September 1, a location in which to provide the CAHC services in the community will be identified and secured.

Objective 6: By September 1, a plan of operation will be developed and submitted to MDCH and MDE for approval, which identifies next steps with a timeline for initiating a CAHC.

Please note that if your community has already achieved one or more of the mandatory objectives through an existing planning process, please describe this in your work plan and include any documentation and/or evidence of completion as attachments. MDCH and MDE reserve the right to determine the extent to which the provided documentation fulfills the requirements of the objectives.

Required Reports and Trainings for Planning Grantees:

The following reports and trainings are required of all planning communities and should be integrated into the work plan and budget as needed.

Reporting Requirements

- Narrative progress reports are due June 1 and August 1, 2009.
- Final report, which includes an implementation plan for FY 10, is due September 1, 2009.

Required Trainings and Technical Assistance

- A minimum of 3-5 members of your CAC must attend a workshop on "*How to Plan a Child and Adolescent Health Center*," in **April 2009** at a metro Lansing location to learn about conducting a needs assessment, putting together component services, and financing and implementing action strategies.
- A minimum of 3-5 members of your CAC must attend and participate in a technical assistance training provided by MDCH in the **Summer of 2009**.

The proposed budget for the planning grant must reflect these required trainings and workshops.

9. Medicaid Outreach Plan (10 points). Due to funding guidelines, each planning community must provide Medicaid Outreach activities to eligible children and youth in their service area throughout the planning process. A preliminary plan with proposed activities should be included at the end of the work plan. **For a list of eligible activities, refer to MSA 04-13, which is included in Attachment I.**

Eligible activities might include the following: providing Medicaid applications to any child or youth focus group or forum that is being conducted as part of the planning process as a strategy

for documenting need; providing Medicaid applications to any parent groups that are sought out during the planning process; provide CAC members with Medicaid brochures to take back to their respective agencies for dissemination; setting aside CAC meeting time to discuss how to strengthen outreach efforts in the community and/or school, etc.

MDCH will provide technical assistance to successful applicants regarding how to integrate Medicaid Outreach activities into the planning process after funds are awarded.

10. Michigan State Board of Education Strategic Goal and Strategic Initiatives (10 points). The State Board of Education has adopted as its Strategic Goal "Attain substantial and meaningful improvement in academic achievement for all students/children with primary emphasis on high priority schools and students." In addition, the State Board has adopted the following four Strategic Initiatives to implement the goal:

- Re-imagine the pre-K-12 educational system in Michigan that will lead to the State Board of Education's expectation for student achievement.
- Continue to review and improve Michigan's teacher preparation system.
- Continue to advocate and promote high school reform, with an emphasis on relevance, relationships, and implementation.
- Implement the "darkening the dotted lines" partnership between the Michigan Department of Education and the intermediate school districts.

Explain how *one* of the Michigan State Board of Education's four strategic initiatives will be addressed through the Child and Adolescent Health Center Grant. Please limit the response to **not more than ONE** typed sheet. To learn more about the four Strategic Initiatives go to: http://www.michigan.gov/documents/MDE_2005_Strategic_Plan_129469_7.pdf .

11. Letters of Commitment (10 points). Letters of commitment to participate from the **superintendent or building principal are required**. Provide a minimum of 3 additional letters of commitment/support from potential or actual partners who will work with you on this planning effort (this could include Local Health Departments). Letters should demonstrate strong evidence of community support for the planning process. **Letters should be included as attachments immediately following the initial roster of Community Advisory Council members.**

12. Letters of Need (8 points). Current letters documenting the lack of services must be obtained from at least three (3) of the following agencies: community mental health, local office of substance abuse services, federally qualified health center (FQHC), local Family Independence Agency (FIA), local hospital, Mayor's office, county health department board or commissioners, school district superintendent or school board, intermediate school district, and/or local public health department. (*If these letters also contain statements supporting the planning process and indicate a commitment to participate in the process, they will contribute to*

the requirements under #11. Letters of Commitment.) **Letters should be included as attachments immediately following the Letters of Commitment.**

13. Financial Plan (20 points). Planning grant requests must not exceed $50,000. Applicants may request an amount up to $50,000. When determining the size of your request, consider such factors as: past or current planning efforts that dealt specifically with starting a CAHC; complexities in local partnerships; amount of work to be accomplished; and other local conditions. The financial plan should be sufficient to achieve the proposed project, but not be excessive. **A minimum local match of 30 percent of the amount requested is required.** The match can be reached either through cash contributions (hard match) or in-kind resources such as donated space or time (soft-match). The Financial Plan should also describe all funding sources and the distribution of these funds as they relate to supporting the proposed planning process.

PART E: Budget

1. **Budget Forms**: Prepare a line-item budget for the period of April 1, 2009, through September 30, 2009 on the Budget Summary and Cost Detail forms for the amount requested (*forms and instructions -Attachment J*). All in-kind resources and hard match must also be included on the budget.
    a. The budget should designate a person (or position) to spend time each week coordinating the planning effort.
    b. The budget should also include funds for a team of 3-5 persons from the CAC to travel for up to two workshops in Spring/Summer of 2009.

2. **Budget Narrative**: The budget narrative must provide a detailed description of planned expenditures, including justification and rationale. All budget line items must be described in the budget narrative *(Guidelines for the Budget Narrative are found in Attachment K*).
    a. If your agency is funded to provide services similar or related to those proposed in this application, provide a list of those funders, amount of award, contract period, and services supported.

3. **Eligible Expenditures**:
    a. Planning Grant funds MUST be used to pay for the following expenditures:
        1. Medicaid Outreach Activities to eligible children, youth, and families
    b. Planning Grant funds MAY be used to pay for the following expenditures:
        1. Materials and supplies
        2. Coordinator/director, manager, and secretarial support salary and fringes
        3. Contractual staff and/or consultants hired to facilitate the planning process
        4. Parent/youth involvement activities
        5. Staff development and teacher/parent training
        6. Travel necessary to enable project staff to implement the program's goals and objectives
        7. Communication
        8. Meeting and training supplies and materials

9. Stipends and substitute reimbursements (if needed)

c. Planning grant funds **MAY NOT** be used to pay for:

1. Indirect costs
2. Capitol costs
3. Architectural costs

Complete the Application Checklist and Fax Back Form for planning grant applicants (Attachment D).

PART V: APPLICATION INFORMATION, INSTRUCTIONS, AND REVIEW CRITERIA FOR CLINICAL AND ALTERNATIVE CLINICAL CHILD & ADOLESCENT HEALTH CENTER GRANTS

REVIEW CRITERIA

All applicants will be evaluated on the basis of the criteria described in this section. Narrative sections of the applications should address each criterion. Applications are not to include pamphlets, handbooks, reports, brochures, news articles, folders, binders, dividers, etc. **Two hundred eighty** is the maximum score that can be obtained for this application, and the value assigned for each section is indicated. Points will be deducted for any proposal narrative that exceeds the 30 written pages allowed in Part C. Required forms and support documents (title page, table of contents, certifications and assurances, list of advisory council members, budget forms, budget narrative, work plan, interagency agreement with school, and letters of commitment and need) are not counted in the narrative page limit.

PART A – APPLICATION COVER SHEET/APPLICATION (Page 1 of the Application)

The organization or agency submitting the application must be fully identified, as well as the direct contact person for this program. All boxes are to be accurately completed. The application requires an original signature from the person with binding authority from the applicant agency. *Rubber stamps and copies are unacceptable.*

1. **Funding Strategy.** Identify the type of program the applicant proposes:

Clinical Child & Adolescent Health Center Model*:

School Based Health Center Model - $175,000

School Linked Health Center Model - $225,000

Federally Qualified Health Center (School Based or School Linked) - $175,000

***Clinical CAHCs must reach a minimum of 500 unduplicated children or youth annually for adolescent (10-21 years old) sites and 350 for elementary (5-10) sites.** Applicants must also identify the total number of children and/or youth in the service area. This information will be used to determine a minimum number of users to be served by each applicant. This number will vary depending on the grantee and the unique geographic characteristics of the service area.

Alternative Clinical Child & Adolescent Health Center:**

School Based Health Center Model - $120,000

***Alternative Clinical CAHCs must reach a minimum of 200 unduplicated children or youth annually.** Applicants must also identify the total number of children and/or youth in the service area. This information will be used to determine a minimum number of users to be served by each applicant. This number will vary depending on the grantee and the unique geographic characteristics of the service area.

2. **Service Area.** Identify the service/target area the requested funds will service (school district, county, city, metropolitan area etc.).

3. **Target Population**. Identify the age group of the target population that will be served by the proposed project. **Please identify the primary age group that will be served**.

Children ages 5-10 (Elementary Age Population)

Youth ages 10-21 (Middle and High School Age Population and Young Adults)

Please note that there are separate Minimum Program Requirements (MPRs) for clinical centers serving the 5-10 year old population versus centers serving the 10-21 year old population. If the grantee plans on serving both age groups, they must adhere to both MPRs, which are included in *Attachment C*. Please also note that if the Adolescent (10-21 year old) population is being served, the applicant must provide a teen-friendly clinic atmosphere that is both acceptable and accessible to this population. *Serving young children must not pose a barrier to the teen population accessing this center.* Applicants are encouraged to choose one of the age groups listed above. Please note that if the majority of clients served fit in one of the two age groups, please only check the age group that encompasses the majority of the population that will be accessing this center. If both populations are proposed to be served equally, the applicant must provide a detailed description of how they will ensure that the teen population will view this clinic as accessible and acceptable.

PART B - ASSURANCES

To be eligible for funding, all applicants must provide written assurance that abortion services, counseling and referrals for abortion services will not be provided as part of the services offered. For programs providing services on school property, written assurance will be required that family planning drugs and/or devices will not be prescribed, dispensed or otherwise distributed on school property as mandated in Michigan School Code. Proposals must include a statement of assurance of compliance with all federal and state laws and regulations prohibiting discrimination and with all requirements and regulations of the Michigan Department of Education and Michigan Department of Community Health. **These assurances must be included in the application cover letter.**

PART C – GRANT PROGRAM DETAILS (280 POINTS)

1. **Table of Contents.** Provide a table of contents with corresponding page numbers on each page of the application. Attachments should be paginated and listed in the table of contents.

2. **Project Abstract/Summary (10 points).** Provide NO MORE THAN A TWO PAGE, single-spaced summary of the proposal. Explain briefly:
    A. Organization's history of administering programming for which this application requests funds;
    B. Statement of need for the proposed program, the target area and population the program will serve, and the number of unduplicated children and/or youth expected to be reached in the first year of funding;
    C. A summary of the major program goals and expected outcomes;
    D. A brief description of the proposed programming including a description of where services will be provided (include a brief description of the clinic space);
    E. Total amount of local resources which will be applied to the project and how they will be used (30% local match requirement); and

F. Highlight key people who will be involved with the project.

3. **Assessment of Need (60 points).** The proposal must include documentation from multiple sources on the lack of accessible and child or youth-acceptable services in the geographic area proposed to be served. The need/demand for services must be well documented. **Proposals failing to meet these criteria will not be considered for funding.**

   A. Provide a map of the proposed service area

   B. Provide descriptive and demographic information of the service area including:
      1. Service area definition
      2. Economic status of the population
      3. Other agencies providing similar services as those proposed
      4. Data on estimated need/demand for the proposed services
      5. Description of other unusual factors affecting the need for the proposed services

   C. Describe the characteristics of the target population including:
      1. Size of the target population
      2. Age of the target population (applicants are encouraged to select either the 5-10 year old population or the 10-21 year old population; if both populations will be equally served, please provide a detailed explanation for how teen-friendly services will be provided that are both accessible and acceptable to this 10-21 year old age group)
      3. Economic status of the target population (at a minimum, include number of children or youth in the target population that receive free or reduced price school lunch)
      4. Gender and racial make-up of the target population
      5. Health status and level of risk-taking behaviors

   D. Identify and include the results of a health survey that has been conducted in the previous three years to assess the target population's health needs.

   E. Current letters documenting the lack of services must be obtained from at least three (3) of the following agencies: community mental health, local office of substance abuse services, federally qualified health centers (FQHCs), local Family Independence Agency (FIA), local hospital, Mayor's office, county health department board or commissioners, school district superintendent or school board, intermediate school district and/or local public health department. (*If these letters also contain statements supporting the proposal and the applicant's ability to accomplish the proposal, they will contribute to the requirements under "5. Community Collaboration/Support*.")

4. **Community Experience (30 points).** Briefly describe the community's historical commitment to the proposed program as well as its support for school-based/school-linked health services for the adolescent population (if adolescents are proposed to be served) or young children (if the 5-10 year old age group is to be served). Provide evidence of the applicant organization's ability to accomplish the proposed service/work plan and manage a grant program of similar size and complexity. Include a description of services provided by

the applicant organization, which are similar to or which compliment the proposed services. Finally, briefly summarize the applicant's present or past experience mobilizing, establishing and maintaining a community-based, broadly representative local advisory committee with a health-related mission.

5. **Community Collaboration/Support (30 points).** The proposal should demonstrate the support of other related service providers and the general community. Provide a description of the available community resources, which will help sustain the proposed program (both hard match and/or in-kind services).

   Provide a listing of collaborative and referral arrangements which will be utilized for the proposed programming. The listing should include, at a minimum, other programs that provide similar or related services to the target population and how the proposed program will interact with (i.e. refer to and/or accept referrals from) these organizations but not duplicate efforts.

   Provide a minimum of five (5) letters of endorsement for the proposal which indicate that other agencies and the general community believe the applicant agency is able to successfully accomplish the proposed program, that the program will meet the described needs and what they are willing to contribute toward the support of the program. Evidence of the involvement of local agencies or community members in the proposed program should also be included**.**

6. **Advisory Committee Structure, Membership and Activity (15 points).** Describe the current or proposed structure of the committee including membership, leadership, sub-committees, activities, procedures for developing/approving policy and frequency of meetings. See Minimum Program Requirement #14 for both Elementary and Adolescent Clinical and Alternative Health Centers for specific regulations regarding the composition of the membership, frequency of meetings and policy requirements. *Please note that parents of school-aged children and youth must be included on the advisory committee.* Provide a copy of the existing or the potential advisory committee membership list in the attachments. Outline the plan to recruit and maintain diverse members that are representative of the racial, ethnic, economic and philosophical diversity of the target area.

   If policies and procedures on the following topics already exist and have been approved by the advisory committee, include them as attachments to the proposal:
   - ✓ Parental consent.
   - ✓ Requests for medical records and release of information that include the role of the non-custodial parent and parents with joint custody.
   - ✓ Confidential services (*adolescent centers only*).
   - ✓ Disclosure by clients or evidence of child physical or sexual abuse and/or neglect.

7. **Organizational Structure (25 points).** Describe the administrative and organizational structure within which the program and the advisory committee will function. Submit as an attachment an organizational chart depicting the program, including the advisory committee, the fiduciary agency, program coordinator, proposed subcontractors (if applicable) and all related program personnel.

Describe the number of staff and/or volunteers who will provide the proposed services including a description of the skills/qualifications necessary. Include in the attachments job descriptions or vitae (if available) of the personnel who will play key roles in the administration of the project and the delivery of services. See the attached minimum program requirements for a description of required providers and clinical hours of operation (MPR #10, #11, and #12 for Adolescent Health Centers and MPR # 9, #10, #11, and #12 for Elementary Centers). Provide a description of how program coordination will occur, including any full-time equivalents (FTEs) dedicated to overseeing and coordinating administrative functions. Briefly describe the staff development opportunities that will be made available to the staff or required of them.

8. **Service Plan Narrative (50 points).** Services proposed to be provided should be fully and clearly described for the period **April 1, 2009 through September 30, 2009**. Please provide a service/work plan for this time period as well.

The services as described in this proposal must be operational and accessible to the described target population by August 1, 2009.

A. Provide a description of the services that will be provided at the center.

B. Describe the case finding system that will be used to identify and recruit clients.

C. Describe the proposed referral system.

D. Describe the proposed or actual hours of operation and arrangements for after-hours coverage.

E. Indicate the number of unduplicated children and/or youth to be served in the course of the fiscal year**. A minimum of 500 unduplicated users must be proposed and served for Adolescent Clinical Centers, a minimum of 350 for Elementary Clinical Centers, and a minimum of 200 unduplicated users for Alternative Clinical Centers.** Please note that a minimum number of users will be negotiated with MDCH for FY 10 for each grantee and will take into account a number of factors including, the proposed number of users included in the work plan, size of service area and historical utilization numbers.

F. Describe where and how services will be provided. If the selected site is a location other than on school property, justify the accessibility of the site for the target population. **If the selected site is on school property, a copy of an interagency agreement between the sponsoring agency and the local school district must be included with the proposal, which defines roles and responsibilities.**

G. Describe the layout of the clinical space including dimensions, handicapped accessibility and how services will be provided in a confidential manner, including records.

H. Briefly describe the organization's plan to comply with Occupational Safety and Health Act (OSHA) guidelines regarding transmission of blood borne pathogens, and laboratory guidelines, if applicable.

I. If services will be provided on school property, written approval by the school administration and the local school board must be submitted with the proposal for the following items:

- ✓ Location of the health center.
- ✓ Administration of a health survey to students enrolled in the school.
- ✓ Parental consent policy.
- ✓ Services rendered in the health center program.

J. Describe the applicant organization's plans to assure that quality services are provided through this program. See *Attachment C*, Minimum Program Requirements (MPRs), for a description of the required components of a quality assurance plan. *Please note that there are separate MPRs for clinical centers serving the elementary age population versus clinical centers serving the adolescent and young adult population.*

K. Describe how your agency will provide Medicaid Outreach activities and facilitate access to Medicaid preventive services to eligible children and youth in your target area. The outreach plan should also describe how eligible children and youth will be identified. Clinical and Alternative Clinical CAHCs must follow Activities 1-5 as outlined in **Medicaid Bulletin 04-13**, which is included in *Attachment I*. **In the work plan, at least one goal must be included, with measurable objectives and activities related to Medicaid Outreach and facilitating access to Medicaid preventive screenings**.

L. Describe how youth input will occur, if providing services to the adolescent population. For elementary centers, describe how the health needs of children in the service area will be integrated into the center's service delivery plan and describe how parents will be involved at the center.

M. Describe how the program will be evaluated, such as goals and measurable objectives, client satisfaction surveys, focus groups or other methodologies.

9. **Work Plan (25 points).** List the overall program goal(s), and measurable, time-framed objectives using the required format included in *Attachment H*. Objectives should be SMART (Specific, Measurable, Appropriate, Realistic and Time-phased) and address the needs of the target population. If providing services to the adolescent population, describe how youth input will occur and how services will be youth-friendly and acceptable to youth. When completing this section, **carefully review the Minimum Program Requirements included in Attachment C.** It is imperative that the required services addressed in the attached Minimum Program Requirements (MPR #1 and #2) are specifically addressed.

   Mandatory Focus Areas – In FY 10, each center should provide full implementation of at least 2 of the following mandatory areas of focus. Each focus area should have a goal with

corresponding objectives and activities that outline your center's plan for addressing the focus area. Centers are encouraged to look at the needs of the target population when determining which areas of focus will be selected for FY 10. **FY 09 workplans MUST include planning for delivery of focus areas in FY 10.**

FY 10 Mandatory Focus Areas (*select at least 2*):

1. **Pregnancy Prevention*** – address any efforts your center will undertake to reduce or impact teen pregnancy prevention.
2. **Overweight/Obesity/Nutrition/Physical Activity** – address how your center will impact youth obesity and promote nutrition and physical activity to high-risk youth.
3. **HIV/AIDS*** – address how your center will provide either education on HIV/AIDS; outreach, referral, and/or access to confidential HIV counseling and testing; and/or risk reduction to high-risk youth.
4. **Tobacco Prevention/Cessation**– address any efforts your center will undertake to impact tobacco use among youth.
5. **Asthma**—address any efforts your center will undertake to impact asthma and improve health outcomes among youth.
6. **Mental Health**—address how your center will meet the mental health needs of youth.

*Note that for both pregnancy prevention and HIV/AIDS focus areas, approval from the reproductive health advisory board for any in-school health education must be documented in the application.

10. **Michigan State Board of Education Grant Strategic Goal and Strategic Initiatives (10 points).** The State Board of Education has adopted as its Strategic Goal "Attain substantial and meaningful improvement in academic achievement for all students/children with primary emphasis on high priority schools and students." In addition, the State Board has adopted the following four Strategic Initiatives to implement the goal:

    - Re-imagine the pre-K-12 educational system in Michigan that will lead to the State Board of Education's expectation for student achievement.
    - Continue to review and improve Michigan's teacher preparation system.
    - Continue to advocate and promote high school reform, with an emphasis on relevance, relationships, and implementation.
    - Implement the "darkening the dotted lines" partnership between the Michigan Department of Education and the intermediate school districts.

Explain how *one* of the Michigan State Board of Education's four strategic initiatives will be addressed through the Child and Adolescent Health Center Grant. Please limit the response to

not more than ONE typed sheet. To learn more about the four Strategic Initiatives go to: http://www.michigan.gov/documents/MDE_2005_Strategic_Plan_129469_7.pdf .

11. Financial Plan (25 points). The financial plan should be sufficient to achieve the proposed project, but not be excessive. **A minimum local match of 30% of the amount requested is required.** The match can be reached either through cash contributions (hard match) or in-kind resources such as donated space or time (soft-match). The financial plan should also address the following:

A. Briefly describe all funding sources and the distribution of these funds.

B. For existing centers that are not currently funded by the State, this funding must not be used to supplant current funding supporting clinic services. Please detail how this funding will be used to **expand on** the existing financial support of the center and not supplant current funding streams.

C. Describe the proposed fee schedule and how it will be applied (see minimum program requirements for CAHCs, which address that services cannot be denied because of inability to pay).

D. Describe the billing system that will be used to recover appropriate revenues from third-party payers, if applicable.

E. Describe how the billing and fee collection processes protect client confidentiality.

PART D: BUDGET

12. Budget Forms: Prepare a line-item budget for the period of April 1, 2009 through September 30, 2009 on the **Budget Summary** and **Cost Detail Forms** for the amount requested (*forms and instructions – Attachment J*). **Total amount requested for the initial six month period for Clinical and Alternative Clinical Health Centers should be 50% of the full year allocation.** All in-kind resources and hard match must also be included on the budget.

13. Budget Narrative: Budget narratives must provide detailed descriptions of planned expenditures, including justification and rationale. All budget line items must be described in the budget narrative (*Guidelines for the Budget Narrative are found in Attachment K*).

A. If your agency is currently funded to provide services similar or related to those proposed in this application, provide a list of the funding source(s), amount of award, contract period, and services supported.

Attachment A

SECTION 31a, SUBSECTION 6
OF THE
STATE SCHOOL AID ACT

(6) From the funds allocated under subsection (1), there is allocated for 2008-2009 an amount not to exceed $4,743,000.00 to support child and adolescent health centers. These grants shall be awarded for 5 consecutive years beginning with 2003-2004 in a form and manner approved jointly by the department and the department of community health. Each grant recipient shall remain in compliance with the terms of the grant award or shall forfeit the grant award for the duration of the 5-year period after the noncompliance. Beginning in 2004-2005, to continue to receive funding for a child and adolescent health center under this section a grant recipient shall ensure that the child and adolescent health center has an advisory committee and that at least one-third of the members of the advisory committee are parents or legal guardians of school aged children. A child and adolescent health center program shall recognize the role of a child's parents or legal guardian in the physical and emotional wellbeing of the child. Funding under this subsection shall be used to support child and adolescent health center services provided to children up to age 21. If any funds allocated under this subsection are not used for the purposes of this subsection for the fiscal year in which they are allocated, those unused funds shall be used that fiscal year to avoid or minimize any proration that would otherwise be required under subsection (14) for that fiscal year.

Attachment B

Key Terms and Definitions for Child & Adolescent Health Center Competitive Process:

NEW START: is defined as a center that is not currently operational/receiving state funding, but could be up and running and meeting state MPRs within 120 days of receipt of the contract.

PLANNING COMMUNITY: is defined as a community interested in convening a planning process to determine the feasibility of establishing a new Clinical or Alternative Clinical Child & Adolescent Health Center, a community that is in the process of planning, **OR** has undergone a planning effort but is not able to meet State-defined MPRs within 120 days of the start of the contract. Only applicants that do not have a health center in their area are eligible to apply for this model.

CLINICAL SCHOOL BASED HEALTH CENTER: is defined as a health center located in a school or on school grounds that provides on-site comprehensive primary and preventative health services, including referrals, tracking and follow-up, throughout the year with signed agreements with the host school and/or local school district. The SBHC is expected to operate at least 30 hours, 5 days per week at a single location and provide 24-hour backup coverage to all students and users enrolled in the SBHC. The 30 hours of clinic services must be provided by a certified Nurse Practitioner (PNP, FNP, SNP), Physician Assistant, or a Physician. School Based Health Centers can be located in elementary, middle, high, or alternative schools and must follow School Code Regulations.

CLINICAL SCHOOL LINKED HEALTH CENTER: is defined as a health center NOT LOCATED ON SCHOOL PROPERTY that provides on-site comprehensive primary and preventative health services, including referrals, tracking and follow-up, throughout the year to adolescents and young adults. A school-linked health center is located in the community at an accessible location and has strong ties to area schools. The primary population of adolescents should come from the local schools. A school-linked health center is expected to operate at least 30 hours, 5 days per week at a single location in an adolescents-only environment and provide 24-hour backup coverage to all adolescents, young adults and users enrolled in the center. The 30 hours of clinic services must be provided by a certified Nurse Practitioner (PNP, SNP, FNP), Physician Assistant, or a Physician. A school-linked health center does <u>not</u> have to follow School Code Regulations. School-linked health centers provide services to youth ages 10-21 and the small children of the adolescent population.

ALTERNATIVE CLINICAL HEALTH CENTER: is defined as a health center located in a school or on school grounds that provides on-site comprehensive primary and preventative health services, including referrals, tracking and follow-up, throughout the year with signed agreements with the host school and/or local school district. The ACHC is expected to operate at a single location least 24 hours per week (a minimum of 3 days per week with consistent days each week) and provide 24-hour backup coverage to all students and users enrolled in the ACHC. The

24 hours of clinic services must be provided by a certified Nurse Practitioner (PNP, FNP, SNP), Physician Assistant, or a Physician. The ACHC can be located in elementary, middle, high, or alternative school and must follow School Code Regulations.

SERVICE AREA: is defined as a geographic area with precise boundaries (e.g. school district, county). The size of the service area should be appropriate to provide services in a timely and appropriate fashion.

TARGET POPULATION: is defined as a subset of the entire service area population (e.g. school building, city, or other). For the purpose of this program, the eligible target population is 5-21 year olds and the small children of the adolescent population. The description of the target population should include the major health problems of the target population and should serve as the basis for the center's service delivery plan.

Attachment C

MINIMUM PROGRAM REQUIREMENTS FOR CHILD AND ADOLESCENT HEALTH CENTERS
ADOLESCENT SITES

ELEMENT DEFINITION:

Services designed specifically for persons 10 through 21 years of age aimed at achieving the best possible physical, intellectual, and emotional status. Included in this element are: 1) Adolescent Health Centers designed to provide primary care, psychosocial and health promotion/disease prevention, and outreach services. The infants and small children of the target age group can be served through this program; and 2) Non-clinical Adolescent Health Centers designed to provide health education, peer counseling, screening/case finding services, referral for primary and/or specialty care, limited clinical services, outreach services and/or health related community awareness activities.

MINIMUM PROGRAM REQUIREMENTS FOR CLINICAL AND ALTERNATIVE CLINICAL ADOLESCENT HEALTH CENTERS:

Services

1. The adolescent health center shall provide a range of support services that are high quality, acceptable and accessible to youth in their target population. The adolescent health center shall provide a minimum of two of the following thirteen teen specific support services: mental health counseling, drug/alcohol awareness, support groups, smoking cessation programs, sexual abuse counseling, tutoring, job skills training, suicide prevention programs, support for eating disorders, nutritional counseling, teen advisory groups, parenting education, support for intimate partner violence, and peer education and counseling.

2. The adolescent health center shall provide a range of services based on the needs determined through the adolescent health survey, and approved by the advisory committee. At a minimum the services shall include immunization screening and administration with the utilization of the Michigan Care Improvement Registry, primary care including health maintenance (well care), EPSDT screening, and care for acute illness and chronic conditions, referral for other needed clinical services not available at the teen health center, HIV and STD education, and voluntary counseling and testing, and shall follow preventive services guidelines (such as GAPS or Bright Futures).

3. The adolescent health center shall not, as part of the services offered, provide abortion counseling, services, or make referrals for abortion services.

4. The clinical services provided shall meet the recognized, current standards of practice for care and treatment of adolescents and their children.

5. The adolescent health center, if on school property, shall not prescribe, dispense, or otherwise distribute family planning drugs and/or devices.

6. The adolescent health center shall provide Medicaid outreach services to eligible youth and families and shall adhere to Child and Adolescent Health Centers and Programs (CAHCPs) outreach activities as outlined in MSA 04-13.

Administrative

7. Written approval by the school administration and local school board exists for the following:

    a) location of the health center if located on school property or in a building where K-12 education is provided;
    b) administration of a health survey to students enrolled in the school;
    c) parental consent policy if services are provided in a building where K-12 education is provided;
    d) services rendered in the health center if the center is located on school property where K-12 education is provided.

8. If the health center is located on school property, it shall have a current interagency agreement defining roles and responsibilities between the contracting agency and the local school district.

9. The adolescent health center shall be located in a school building or an easily accessible alternate location. NOTE: Alternative Clinical Centers must be school-based.

10. The health center shall be open during hours accessible to its target population, and provisions must be in place for the same services to be delivered during times when school is not in session. Not in session refers to times of the year when schools are closed for extended periods, such as holiday, spring breaks, and summer vacation. These provisions shall be either posted, given to and/or explained to clients including at a minimum an answering service/machine message.

    Clinical Centers: The center shall provide clinical services a minimum of five days a week. Total provider clinical time shall be at least 30 hours per week. Hours of operation must be posted in areas frequented by the target population. The adolescent health center shall have a written plan for after-hours and weekend care, which shall be posted, given to, and/or explained to clients.

    Alternative Clinical Centers: The center shall provide clinical services a minimum of three days a week (days must be consistent each week). Total provider clinical time shall be at least 24 hours per week. Hours of operation must be posted in areas frequented by

the target population. The adolescent health center shall have a written plan for after-hours and weekend care, which shall be posted, given to, and/or explained to clients.

11. The adolescent health center shall have a licensed physician as a medical director who supervises the medical services provided. Written standing orders and clinical procedures approved by the medical director and the contracting agency shall be available for use by clinical staff.

12. The health center shall be staffed by a certified nurse practitioner (FNP, PNP, or SNP), licensed physician, or a licensed physician assistant working under the supervision of a physician during all hours of clinic operation. The nurse practitioner must be certified or eligible for certification in Michigan and accredited by an appropriate national certification association or board. The physician and physician assistant must be licensed to practice in Michigan.

13. The health center shall implement a quality assurance plan. Components of the plan shall include at a minimum:
    a) ongoing clinical and medical records reviews by peers to determine that conformity exists with current standards of practice. A system shall also be in place to implement corrective actions when deficiencies are noted.
    b) completing, updating, or having access to an adolescent health survey/assessment done within the last two to three years to determine the health needs of the target population.
    c) conducting a client satisfaction survey/assessment periodically, but no less than once per year.

14. A local advisory committee shall be established and operated as follows:
    a) A minimum of two meetings per year.
    b) The committee must be representative of the community and must be comprised of at least 50% members of the community; one-third of members must be parents of school-aged children and youth.
    c) Health care providers shall not represent more than 50% of the committee.
    d) The committee should recommend the implementation and types of services rendered by an adolescent health center.
    e) The advisory committee must approve the following policies and the adolescent health center must develop applicable procedures:

        1. Parental consent;
        2. Requests for medical records and release of information that include the role of the noncustodial parent and parents with joint custody;
        3. Confidential services; and
        4. Disclosure by clients or evidence of child physical or sexual abuse, and/or neglect

    f) Youth input to the advisory committee shall be maintained through either membership on the established local advisory committee; a youth advisory

committee; or through other formalized mechanisms of youth involvement and input.

15. The health center shall have space and equipment adequate for private physical examinations, private counseling, reception, laboratory services, secured storage for supplies and equipment, and secure paper and electronic client records. The physical facility must be barrier-free, clean, and safe.

16. The health center staff shall follow all Occupational Safety and Health Act guidelines regarding transmission of blood borne pathogens, such as HIV and Hepatitis B, to health care and Public Safety Workers.

17. The health center shall conform to the regulations determined by the Department of Health and Human Services for laboratory standards.

Billing and Fee Collection

18. The adolescent health center shall establish and implement a sliding fee scale, which is not a barrier to health care for teens. Adolescents must not be denied services because of inability to pay.

19. The adolescent health center shall establish and implement a process for billing Medicaid, Medicaid Health Plans and other third party payers.

20. The billing and fee collection processes do not breach the confidentiality of the client.

MINIMUM PROGRAM REQUIREMENTS FOR
CHILD AND ADOLESCENT HEALTH CENTERS
ELEMENTARY SITES

ELEMENT DEFINITION:

Services designed specifically for elementary school-aged children 5-10 years of age aimed at achieving the best possible physical, intellectual, and emotional status. Included in this element are Elementary School Based Health Centers designed to provide primary care, psychosocial and health promotion/disease prevention, and outreach services.

MINIMUM PROGRAM REQUIREMENTS FOR CLINICAL AND ALTERNATIVE CLINICAL ELEMENTARY SCHOOL BASED HEALTH CENTERS:

Services

1. The elementary health center shall provide a range of services based on a needs assessment of the community/target population and approved by the advisory committee. At a minimum the services shall include immunization screening and administration with the utilization of the Michigan Care Improvement Registry, primary care including health maintenance (well child/EPSDT) and care for acute illness and chronic conditions, laboratory tests for pregnancy, communicable diseases and primary prevention, mental health counseling, access or referral to dental services, referral for other needed clinical services not available at the elementary health center, health education including communicable disease education, and shall follow preventive services guidelines (such as American Academy of Pediatrics, Bright Futures, etc.).

2. The elementary health center shall not, as part of the services offered, provide abortion counseling, services, or make referrals for abortion services.

3. The clinical services provided shall meet the recognized, current standards of practice for care and treatment of elementary school-aged children (ages 5-10).

4. The elementary health center, if on school property, shall not prescribe, dispense, or otherwise distribute family planning drugs and/or devices.

5. The elementary health center shall provide Medicaid outreach services to eligible children and families and shall adhere to Child and Adolescent Health Centers and Programs (CAHCPs) outreach activities as outlined in MSA 04-13

Administrative

6. Written approval by the school administration and local school board exists for the following:

    a) location of the elementary health center on school property or in a building where K-5 education is provided;
    b) administration of a needs assessment process to determine priority health services;
    c) parental consent policy;
    d) services rendered in the health center;
    e) policy and procedure on how children will access the center during school hours.

7. The elementary health center shall have a current interagency agreement defining roles and responsibilities between the contracting agency and the local school district.

8. The elementary health center shall be accessible to all students enrolled in the school building.

9. The elementary health center shall be open during hours accessible to its target population, and provisions must be in place for the same services to be delivered during times when school is not in session. Not in session refers to times of the year when schools are closed for extended periods, such as holiday, spring breaks, and summer vacation. These provisions shall be posted, given to and/or explained to clients, and presented in writing to parents or guardians and school staff including an answering service/machine message.

    Clinical Centers: The center shall provide clinical services a minimum of five days a week. Total provider clinical time shall be at least 30 hours per week. Hours of operation must be posted in areas frequented by the target population. The elementary health center shall have a written plan for after-hours and weekend care, which shall be posted, given to, and/or explained to clients.

    Alternative Clinical Centers: The center shall provide clinical services a minimum of three days a week (days must be consistent each week). Total provider clinical time shall be at least 24 hours per week. Hours of operation must be posted in areas frequented by the target population. The elementary health center shall have a written plan for after-hours and weekend care, which shall be posted, given to, and/or explained to clients.

10. The elementary health center shall have a licensed physician as a medical director who supervises the medical services provided. Written standing orders and clinical procedures approved by the medical director and the contracting agency shall be available for use by clinical staff.

11. The elementary health center shall be staffed by a certified nurse practitioner (PNP, FNP, SNP), licensed physician, or a licensed physicians assistant with pediatrics experience working under the supervision of a physician during all hours of clinic operation. The nurse

practitioner must be certified or eligible for certification in Michigan and accredited by an appropriate national certification association or board. The physician and physician assistant must be licensed to practice in Michigan.

12. The elementary health center must be staffed with a minimum of a .5 FTE Maters level licensed counselor and/or certified Social Worker. Appropriate supervision must be provided.

13. The elementary health center shall implement a quality assurance plan. Components of the plan shall include at a minimum:
    a) ongoing clinical and medical records reviews by peers to determine that conformity exists with current standards of practice. A system shall also be in place to implement corrective actions when deficiencies are noted.
    b) completing, updating, or having access to a comprehensive needs assessment done within the last two to three years to determine the health needs of the target population.
    c) conducting an age-appropriate client satisfaction survey/assessment periodically, and/or satisfaction surveys with parents and/or school staff, but no less than once per year.

14. A local advisory committee shall be established and operated as follows:
    a) A minimum of two meetings per year.
    b) The committee must be representative of the community and must be comprised of at least 50% members of the community.
    c) Health care providers shall not represent more than 50% of the committee.
    d) Parents must be represented on the committee with at least 1/3 of the committee comprised of parents of school-aged children.
    e) School staff must be represented on the committee, including at least one of the following: school nurses (if applicable), administrative positions, teachers, specialty school program staff, student support team members.
    f) The committee should recommend the implementation and types of services rendered by the health center.
    g) The advisory committee must approve the following policies and the elementary school health center must develop applicable procedures:

        1. Parental consent;
        2. Requests for medical records and release of information that include the role of the noncustodial parent and parents with joint custody;
        3. Confidential services; and
        4. Disclosure by clients or evidence of child physical or sexual abuse, and/or neglect

15. The elementary health center shall have space and equipment adequate for private physical examinations, private counseling, reception, laboratory services, secured storage for supplies and equipment, and secure paper and electronic client records. The physical facility must be barrier-free, clean, and safe.

16. The elementary health center staff shall follow all Occupational Safety and Health Act guidelines regarding transmission of blood borne pathogens, such as HIV and Hepatitis B, to health care and Public Safety Workers.

17. The elementary health center shall conform to the regulations determined by the Department of Health and Human Services for laboratory standards.

Billing and Fee Collection

18. The elementary health center shall establish and implement a sliding fee scale, which is not a barrier to health care for children. No child can be denied services because of inability to pay.

19. The elementary health center shall establish and implement a process for billing Medicaid, Fee For Service Medicaid, Qualified Health Plans and other third party payers.

20. The elementary health center must establish a process for working with assigned Primary Care Providers (PCP), which includes at a minimum a process for informing the PCP when a child is seen at the health center and the level of service that occurred.

REV. 10/08

Attachment D

APPLICATION CHECKLIST AND FAX BACK FORM FOR PLANNING GRANT APPLICANTS:

Sponsoring Agency: _____

Clinic Name: _____

Contact Name: _____ **Fax**: _____

- ❑ Is the Fax-Back Form: Confirmation of Receipt completed?
- ❑ Is the Application Cover Page signed by the authorized signatory?
- ❑ Is the Service Area and Target Population Demographic Worksheet completed?
- ❑ Does the cover letter include the appropriate assurances regarding prescribing/dispensing family planning devices and abortion counseling/services/referral?
- ❑ Is the narrative double-spaced and typed in a font no smaller than Times 12 point?
- ❑ Is the narrative complete (i.e. responds to numbers 1-7 of the planning guidance and the financial plan section)?
- ❑ Does the workplan follow the required format?
- ❑ Are all budget pages complete and accurate?
- ❑ Is the Need Statement Worksheet complete and accurate?
- ❑ Is a map of the proposed service area included?
- ❑ Is the initial roster of Community Advisory Council members included?
- ❑ Have you included Letters of Commitment from the superintendent's office or building principal ***and*** at least three additional Letters of Commitment to participate from local partners interested in participating on the Community Advisory Council?
- ❑ Have you included at least three Letters of Need from suggested local agencies? (*If these letters also contain statements supporting the planning process and indicate a commitment to participate in the process, they will contribute to the requirements under Letters of Commitment as well.)*
- ❑ Have you included 1 original and 4 complete copies of the application?

ASSEMBLE THE ORIGINAL PLANNING GRANT AND FOUR COPIES IN THE FOLLOWING ORDER:

Fax-Back Form: Confirmation of Receipt with all information COMPLETE
Part A -Application Cover Sheet with original signatures
-Service Area and Target Population Demographics Worksheet
Part B –Cover Letter and Assurances
Part C – Grant Program Details

- Title Page
- Table of Contents
- Narrative description of all requested information
- Workplan in required format
- Financial Plan

Part D -- Budget, Budget Summary, Budget Detail and other required budget information
Attachments

- Need Statement Worksheet
- Map of proposed service area
- Initial roster of Community Advisory Council members
- Letters of Commitment
- Letters of Need

APPLICATION CHECKLIST AND FAX BACK FORM FOR CLINICAL AND ALTERNATIVE CLINICAL HEALTH CENTERS:

Sponsoring Agency: _____

Clinic Name: _____

Contact Name: _____ **Fax**: _____

- ❑ Is the Fax-Back Form: Confirmation of Receipt completed?
- ❑ Is the Application Cover Page completed ***and*** signed by the authorized signatory?
- ❑ Does the cover letter include the appropriate assurances regarding family planning devices and abortion counseling/services/referral ***and*** contain original signatures?
- ❑ Is the narrative double-spaced and typed in a font no smaller than Times 12 point?
- ❑ Is the narrative complete (i.e. responds to numbers 2-8 of the existing centers guidance and financial plan section)?
- ❑ Does the workplan follow the required format?
- ❑ Are all budget pages complete and accurate?
- ❑ Is the Budget Summary signed by the authorized signatory?
- ❑ Is a map of the proposed service area included?
- ❑ Have you included Letters of Commitment from the superintendent's office or building principal ***and*** at least three additional Letters of Commitment to participate from local partners interested in participating on the Community Advisory Council?
- ❑ Have you included at least three Letters of Need from suggested local agencies? (*If these letters also contain statements supporting the planning process and indicate a commitment to participate in the process, they will contribute to the requirements under Letters of Commitment as well.)*
- ❑ Have you included a membership list of the existing or potential Community Advisory Committee?
- ❑ If available, have you included policies and procedures approved by the Community Advisory Committee for: parental consent, request for medical records and release of information, confidential services (adolescent sites only) and disclosure of child physical or sexual abuse or neglect?
- ❑ Have you included an organizational chart?
- ❑ If the center is located on school, have you included a copy of the interagency agreement between the sponsoring agency and the local school district which defines the roles and responsibilities of each party?
- ❑ If the center is located on school property, have you included written approval by the school administration for: location of the health center, administration of a health

survey to students enrolled in the school, parental consent policy and services rendered in the health center program?

- ❑ Have you included 1 original and 4 complete copies of the application?

ASSEMBLE THE ORIGINAL AND FOUR COPIES IN THE FOLLOWING ORDER:

Fax-Back Form: Confirmation of Receipt with all information COMPLETE
Part A -Application Cover Sheet with original signatures
Part B –Cover Letter and Assurances
Part C – Grant Program Details

- Table of Contents
- Project Abstract
- Narrative description of all requested information
- Workplan in required format
- Financial Plan

Part D -- Budget, Budget Summary, Budget Detail and other required information
Attachments

- Map of proposed service area
- Letters of Need
- Letters of Endorsement
- Proposed or Existing Advisory Group Members
- Policies and Procedures (if available)
- Interagency Agreement with School (if providing services on school property)

Attachment E:

REPORT FACTSHEET FOR PLANNING GRANTEES:

WHEN ARE REPORTS DUE?

Required Report	Due Date
Narrative Progress Reports (includes narrative of progress on objectives and activities as outlined in the proposal, identification of barriers, and identification of any technical assistance needs)	*Progress Reports are due:* June 1, 2009 , August 1, 2009
Final Summary Report including FY 10 Plan of Operation (includes narrative of progress on objectives and activities as outlined in the proposal for the period of April 1, 2009 – September 30, 2009; must also include a detailed plan of operation and implementation timeline for start-up of the proposed CAHC as well as identification of barriers and any technical assistance needs for implementation)	September 1, 2009

WHEN ARE THE FINAL EXPENDITURE REPORTS DUE?

There are two financial expenditure reports that are required for Planning Grantees. These reports should be submitted on the following schedule (*for tracking of expenditures, not invoice for payment*):

Required Report	Due Date
Financial Status Report: DCH-0384(E)	June 30, 2009; November 30, 2009

All reports should be submitted to*:

Taggert Doll, CAHC Program Coordinator
Michigan Department of Community Health
Division of Family and Community Health
109 Michigan Ave, 4th Floor
Lansing MI 48913

Please also send an original copy of the Financial Status Report and the Final Budget Detail to:

Pat Burke, Chief Financial Officer
Michigan Primary Care Association
7215 Westshire Drive
Lansing, Michigan 48917

***Each planning grant will be assigned a Community Consultant. Progress reports should also be sent to your assigned Community Consultant.**

FY09 REPORT FACTSHEET FOR STATE-FUNDED CLINICAL AND ALTERNATIVE CLINICAL CHILD AND ADOLESCENT HEALTH CENTERS

WHEN ARE DATA REPORTS DUE?
There are two *data* reports that are required for state-funded Child and Adolescent Health Centers.

The data reports should include a completed Medicaid Outreach Report Form as a cover sheet.

Data Reports	Due Date
Quarterly Data Report April 1- June 30, 2009	July 30, 2009
Year-end Data Report: Centers funded in FY09 must submit data reports covering the period of April 1-September 30, 2009	October 30, 2009

WHEN ARE FINANCIAL STATUS REPORTS DUE?
Quarterly financial status reports (FSRs) are required for state-funded CAHCs. These reports should be submitted on the following schedule (*for tracking of expenditures, not invoice for payment*):

Required Report	Due Date
Quarterly FSRs (includes expenditures for the previous quarter) April 1 – June 30, 2009	July 30, 2009
Final Financial Status Report (includes expenditures for the period of April 1, 2009-September 30, 2009)	November 30, 2009

Other reports your program is required to submit annually include:

Required Report	Due Date
Annual Summary Report Centers funded in FY09 must submit a narrative of progress on objectives and activities proposed in the FY09 work plan and outreach plan which should cover the period of April 1, 2009 -- September 30, 2009; annual summary reports must follow a required format.	November 30, 2009
Health Education Form Centers funded in FY09 must submit this form for the period of April 1-September 30, 2009.	October 30, 2009

WHO SHOULD WE SUBMIT REPORTS TO?

All reports listed above should be submitted to your assigned community consultant *and* to:

Taggert Doll, Program Coordinator
Adolescent and School Health Unit
Michigan Department of Community Health
Washington Square Building
109 Michigan Avenue, 4th Floor
Lansing MI 48913
dollt@michigan.gov

Please send an original copy of the 6-month and 12-month FSR and the Final Budget Detail to:

Mr. Pat Burke, Chief Financial Officer
Michigan Primary Care Association
7215 Westshire Drive
Lansing, MI 48917
pburke@mpca.net

Attachment F

Service Area and Target Population Demographics Worksheet

Service Area/Target Population to which demographic data applies *(Use the Service Area/Target Population described on page 1 of the application.):*

_____

	Demographic Characteristics	**Service Area / Target Population Data**	
		#	**%**
RACE / ETHNICITY	White (non-Hispanic)		
	Black or African-American (non-Hispanic)		
	Hispanic/Latino		
	American Indian or Alaskan Native		
	Asian/Pacific Islander		
	Other		
	Total Population		
INCOME AS A PERCENT OF POVERTY LEVEL	Below 100 Percent		
	100 to 199 Percent		
	200 Percent and Above		
	Unknown		
PRIMARY THIRD PARTY PAYMENT SOURCE	Medicaid		
	Other Public Insurance (e.g. MI Child)		
	Private Insurance		
	None/Uninsured		
SPECIAL POPULATIONS / OTHER DATA	Population Ages 5-9		
	Population Ages 10 – 14		
	Population Ages 15 – 21		
	Free and Reduce Priced School Lunches		
	Migrant/Agricultural Worker		
	Public Housing Residents		

Provide year and source of data in proposal narrative as directed in narrative instructions.

Attachment G

Need Statement Worksheet

As part of the planning proposal, applicants MUST COMPLETE AND SUBMIT this two-page Need Statement Worksheet. The scoring of the Preliminary Assessment of Needs/Assets of Your Communities children and/or youth section of the proposal will be based on data about the proposed service area/target population as presented in both the narrative and on this worksheet. If service area/target population data are not available for any of the following, the applicant may provide broader data (i.e. county level data) and must indicate the broader area to which the data applies.

The following guidelines are in place for completing the Need Statement Worksheet:

1. All responses must be given in the format requested (i.e., if a percentage is requested, the response must be a percentage; if a rate is requested, the response must be a rate).
2. Use the most geographically focused data available.
3. No more than one response should be submitted for each question.
4. **All responses indicated below should be clearly referenced and explained in the proposal narrative under the Preliminary Assessment of Need/Assets of Youth section.**
5. **Documentation of the year and source of the data in the narrative is required.**
6. Applicants are expected to provide the most recently available data.

1. BARRIERS AND ACCESS TO CARE: Each applicant must respond to **FOUR** of the following in this section:

(a) **Geographic barriers** based on average travel time/distance by the means most commonly used by the target population (e.g., car, public transportation, walking, etc.) from school to the nearest source of primary care that is accessible to the target population (e.g., a physician willing to accept new Medicaid patients and/or has a published sliding fee schedule for people below 200 percent of poverty).

Check ONE of the following:

- ❑ 0 – 20 minutes
- ❑ 21 – 29 minutes
- ❑ 30 – 44 minutes
- ❑ 45 – 59 minutes
- ❑ 60 – 74 minutes
- ❑ 75 + minutes

OR

- ❑ 0 – 10 miles
- ❑ 11 – 19 miles
- ❑ 20 – 29 miles
- ❑ 30 – 49 miles
- ❑ 50 – 59 miles
- ❑ 60 + miles

(b) **Shortage of primary care physicians** necessary to meet the needs of the target population = Designation of the service area as a
Federal Health Professional Shortage Area (HPSA):

- ❑ NO
- ❑ YES

(c) **Percentage of Children Ages 5 to 17 Living in Poverty** in the service area:

- ❑ 0 - 5%
- ❑ 6 - 10%
- ❑ 11 - 15%
- ❑ 16 - 20%
- ❑ 21 - 25%
- ❑ 26+ %

(d) **Percentage of Uninsured Individuals** in the service area [If information is unavailable, use number of individuals below 200 percent of poverty minus the number of Medicaid beneficiaries]:

- ❑ 0 - 5%
- ❑ 6 - 10%
- ❑ 11 - 15%
- ❑ 16 - 20%
- ❑ 21 - 25%
- ❑ 26+ %

(e) **Percentage of Children Age 0 to 18 years in the service area who are insured by Medicaid**:

- ❑ 0 - 9%
- ❑ 10 - 14%
- ❑ 15 - 24%
- ❑ 25 - 34%
- ❑ 35+ %

2. HEALTH DISPARITY FACTORS: Each applicant must respond to **ten** (**10**) of the following items in the proposal narrative under the Preliminary Assessment of Need/Assets of Youth section.

Responses must be based on the rate/percentage/etc. requested below and should be based on child and adolescent populations, where available and applicable, in the proposed service area/target population. **Please check all of the health disparity factors addressed in the Preliminary Assessment of Need narrative.**

Maternal and Child Health Indicators:

- ❑ Immunization rate
- ❑ Lead poisoning (percent of children tested and percent tested diagnosed as "lead poisoned")
- ❑ Low birth weight rate (per 1,000 live births)
- ❑ Infant mortality rate (per 1,000 live births)
- ❑ Late entry into prenatal care
- ❑ Teen pregnancy rate (per 1,000 female teens) ages 10 to 14 and/or 15 to 19
- ❑ Teen birth rate (per 1,000 female teens) ages 10 to 14 and/or 15 to 19

Chronic and Other Disease and Health Risks:

- ❑ Asthma level (rate or percentage) in youth
- ❑ Asthma hospitalization (rate per 10,000 population ages 1 to 14; other age ranges acceptable if available)
- ❑ Diabetes rate
- ❑ Dental disease rate (e.g., caries, lack of teeth, periodontal disease)
- ❑ Obesity rate
- ❑ Suicide rate
- ❑ HIV/AIDS and STI rates
- ❑ Unintentional injury rate
- ❑ Depression rate
- ❑ Rate of serious mental illness (e.g., schizophrenia, bi-polar, etc.)
- ❑ Substance abuse rate (Identify for which substance/s data is referencing)

Other:

- ❑ Rate of school absenteeism
- ❑ Rate or percentage of school suspension
- ❑ Rate or percentage of school dropout
- ❑ Data from student surveys conducted within last two years: (e.g., health risk behavior or assets surveys): *ONE RESPONSE ONLY*
- ❑ Unemployment rate in the service area
- ❑ Percentage age 5 years or older who speak a language other than English at home
- ❑ Other (must be health related): *ONE RESPONSE ONLY*

Attachment H

Required Work Plan Format for Planning Grants, Clinical and Alternative Model Health Centers

Program Goal: *Specify if Goal is for Mandatory Focus Area or Other Area* Goal should be time-framed and measurable.			
Objectives: Objectives must be time-framed, identify expected outcome measures, and relate to accomplishing the stated goal.			
Services/Activities	**Person Responsible**	**Timeframe**	**Evaluation**
More than one service and/or activity which go beyond any routine clinical services provided must be proposed for each Mandatory Focus Area. Describe each service or activity in detail including: ❑ number of participants ❑ name of program or intervention (if applicable) ❑ identify the source of the program/intervention/standard of care for clinical activity that identifies it as being "evidence-based" or "promising" e.g., provide the *agency name* and *document name or web site address* ❑ location, frequency and duration of service/activity ❑ other supporting details that describe the service or activity that will be provided It is helpful to point out if the activities are integrated or linked to other services and activities in your work plan. Services and activities should be clearly linked to one or more of the stated objectives.	Clearly identify the position(s) responsible for carrying out each service/activity described. Please provide *titles/positions* and *not names* of individuals.	Provide a time frame for *implementing* each service/activity described. In general, do not use September 30, 2009 or October 1, 2008 through September 30, 2009 as the implementation date.	State the evaluation methods / tools (e.g., pre/post test, chart reviews, etc.) for each service or activity.

Attachment I

MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Distribution: Medicaid Health Plans 04-08
Local Health Departments 04-05
Federally Qualified Health Centers 04-01

Issued: August 24, 2004

Subject: Outreach Activities

Effective: October 1, 2004

Programs Affected: Medicaid

Child & Adolescent Health Centers and Programs (CAHCPs), under agreement with the Michigan Department of Community Health, will begin performing Medicaid outreach activities on behalf of the Medicaid Health Plans (MHPs) effective October 1, 2004. CAHCPs were formerly known as school-based, school-linked health centers and the Michigan Model program. This bulletin describes the categories of outreach services that the CAHCPs are expected to perform under the agreement. All outreach activities must be specific to the Medicaid program.

CAHCPs are expected to perform outreach activities to potential and current Medicaid beneficiaries in the following categories:

Medicaid Outreach and Public Awareness
Activities that are to be performed include those associated with informing eligible or potentially eligible individuals about Medicaid covered benefits and how to access them. This includes providing information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services or making referral for such services. This category of outreach also includes coordinating and presenting information about Medicaid through media resources, health fairs and other community forums.

Facilitating Medicaid Eligibility Determination
Activities in this category of Medicaid outreach are related to assisting potential Medicaid eligible individuals in applying for Medicaid benefits. This includes explaining eligibility rules and assisting with the completion of the Medicaid application. It also includes referring individuals to the Michigan Family Independence Agency to make application for benefits.

Program Planning, Policy Development and Interagency Coordination Related to Medical Services
Under this category of outreach activities, the CAHCPs must work collaboratively with other community agencies to assure the delivery of Medicaid-covered services. This includes tracking requests for referrals and coordinating services with the Medicaid Health Plans. Activities that include development of health programs and services targeted to the Medicaid population fall into this category.

Referral, Coordination, and Monitoring of Medicaid Services
Outreach activities in this category include development of program resources for program-specific services at CAHCPs. Coordination of programs and services at the school and/or community levels and monitoring delivery of Medicaid services within the school and/or community are included. CAHCPs may provide information such as that for EPSDT services or making referrals for family planning services.

Medicaid-Specific Training on Outreach Eligibility and Services
Activities that fall into this category of outreach are those that focus on coordinating, conducting, or participating in training and seminars to instruct patients, school personnel, health center staff and community members about the Medicaid program and benefits and how to assist families in accessing Medicaid services. Outreach-related activities include training that enhances early identification, screening and referral of children and adolescents for EPSDT services or behavioral health needs. This category includes development and presentation of training modules regarding Medicaid eligibility and benefits to health center and school health staff and other stakeholders, such as parents and guardians.

Related Documents

The Department will work with the MHPs and the Michigan Primary Care Association (representing the CAHCPs) to develop agreements through which these outreach activities will be coordinated.

Public Comment

Public comment on this bulletin will be accepted and considered for future policy revisions. Comments may be submitted to MDCH Program Policy Division, PO Box 30479, Lansing, MI 48909-7979.

Manual Maintenance

Retain this bulletin for future reference.

Questions

Any questions regarding this bulletin should be directed to Provider Support, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approval

Paul Reinhart, Director
Medical Services Administration

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
INSTRUCTIONS FOR PREPARATION OF BUDGET FORMS (DCH-0385, DCH-0386)

I. INTRODUCTION

The budget should reflect all expenditures and funding sources associated with the program, including fees and collections and local, state and federal funding sources. When developing a budget it is important to note that total expenditures for a program must equal total funds.

The Program Budget Summary (DCH-0385) is utilized to provide a standard format for the presentation of the financial requirements (both expenditure and funding) for each applicable program. Detail information supporting the Program Budget Summary is contained in the Program Budget-Cost Detail Schedule (DCH-0386). General instruction for the completion of these forms follows in Sections II-III. Budgets must be submitted on Michigan Department of Community Health approved forms.

II. PROGRAM BUDGET SUMMARY (DCH-0385) FORM PREPARATION

Use the **Program Budget Summary (DCH-0385)** supplied by the Michigan Department of Community Health. An example of this form is attached **(see Attachment B.1)** for reference. **The DCH-0386 form should be completed prior to completing the DCH-0385 form.** (Please note: the excel workbook version of the DCH 0385-0386 automatically updates the Program Summary amounts as the user completes the DCH-0386).

A. Program - Enter the title of the program.

B. Date Prepared - Enter the date prepared.

C. Page _____ of ____ - Enter the page number of this page and the total number of pages comprising the complete budget package.

D. Contractor Name - Enter the name of the Contractor.

E. Budget Period - Enter the inclusive dates of the budget period.

F. Mailing Address - Enter the complete address of the Contractor.

G. Budget Agreement: Original or Amended - Check whether this is an original budget or an amended budget. The budget attached to the agreement at the time it is signed is considered the original budget although it may have been revised in the negotiation process. If the budget pertains to an amendment, enter the amendment number to which the budget is attached.

H. Federal Identification Number – Enter the Employer Identification Number (EIN), also known as a Federal Tax Identification Number.

PROGRAM BUDGET SUMMARY (DCH-0385) FORM PREPARATION
(continued)

I. Expenditure Category – All expenditure amounts for the DCH-0385 form should be obtained from the total amounts computed on the Program Budget - Cost Detail Schedule (DCH-0386). (See Section III for explanation of expenditure categories.)

Expenditures:

1. Salary and Wages
2. Fringe Benefits
3. Travel
4. Supplies and Materials
5. Contractual (Subcontracts/Subrecipients)
6. Equipment
7. Other Expenses
8. Total Direct Expenditures
9. Indirect Costs
10. Total Expenditures

J. Source of Funds – Refers to the various funding sources that are used to support the program. Funds used to support the program should be recorded in this section according to the following categories:

11. Fees and Collections - Enter the total fees and collections estimated. The total fees and collections represent funds that the program earns through its operation and retains for operation purposes. This includes fees for services, payments by third parties (insurance, patient collections, Medicaid, etc.) and any other collections.

12. State Agreement - Enter the amount of MDCH funding allocated for support of this program. This amount includes all state and federal funds received by the Department that are to be awarded to the Contractor through the agreement.

13. Local - Enter the amount of Contractor funds utilized for support of this program. In-kind and donated services from other agencies/sources should not be included on this line.

14. Federal - Enter the amount of any Federal grants received directly by the Contractor in support of this program and identify the type of grant received in the space provided.

15. Other(s) - Enter and identify the amount of any other funding received. Other funding could consist of foundation grants, United Way grants, private donations, fund-raising, charitable contributions, etc. In-kind and donated services should not be included unless specifically requested by MDCH.

16. Total Funding - The total funding amount is entered on line 16. This amount is determined by adding lines 11 through 15. The total funding amount must be equal to line 10 - Total Expenditures.

K. Total Budget Column - The Program Budget Summary is designed for use in presenting a budget for a specific program agreement funded in part by or through the Department or some other non-local funding source. Total Budget column represents the program budget amount. **The "K" Total Budget column must be completed while the remaining columns are not required unless additional detail is required by the Department.**

III. PROGRAM BUDGET-COST DETAIL SCHEDULE (DCH-0386) FORM PREPARATION

Use the **Program Budget-Cost Detail Schedule (DCH-0386)** supplied by the Michigan Department of Community Health. An example of this form is attached **(see Attachment B.2)** for reference. Use additional pages if needed.

A. Page _____ of _____ - Enter the page number of this page and the total number of pages comprising the complete budget package.

B. Program - Enter the title of the program.

C. Budget Period - Enter the inclusive dates of the budget period.

D. Date Prepared - Enter the date prepared.

E. Contractor Name - Enter the name of the contractor.

F. Budget Agreement: Original or Amended - Check whether this is an original budget or an amended budget. If an amended budget, enter the amendment number to which the budget is attached.

Expenditure Categories:

G. Salary and Wages - Position Description - List all position titles or job descriptions required to staff the program. This category includes compensation paid to all permanent and part-time employees on the payroll of the contractor and assigned directly to the program. This category does not include contractual services, professional fees or personnel hired on a private contract basis. Consulting services, professional fees or personnel hired on a private contracting basis should be included in Other Expenses. Contracts with subrecipient organizations such as cooperating service delivery institutions or delegate agencies should be included in Contractual (Subcontracts/Subrecipients) Expenses.

H. Comments - Enter information to clarify the position description or the calculation of the positions salary and wages or fringe benefits, (i.e., if the employee is limited term and/or does not receive fringe benefits).

I. Positions Required - Enter the number of positions required for the program corresponding to the specific position title or description. This entry could be expressed as a decimal (e.g., Full-time equivalent – FTE) when necessary. If other than a full-time position is budgeted, it is necessary to have a basis in terms of a time study or time reports to support time charged to the program.

J. Total Salary - Compute and enter the total salary cost by multiplying the number of positions required by the annual salary.

PROGRAM BUDGET-COST DETAIL SCHEDULE (DCH-0386) FORM PREPARATION (continued)

K. Salary and Wages Total - Enter a total in the Positions Required column and the Total Salary and Wages column. The total salary and wages amount is transferred to the Program Budget Summary - Salary and Wages expenditure category. If more than one page is required, attach an additional DCH 0386.

L. Fringe Benefits – Check applicable fringe benefits for employees assigned to this program. This category includes the employer's contributions for insurance, retirement, FICA, and other similar benefits for all permanent and part-time employees. Enter composite fringe benefit rate and total amount of fringe benefit. (The composite rate is calculated by dividing the fringe benefit amount by the Salary and Wages amount.)

M. Travel - Enter cost of employee travel (mileage, lodging, registration fees). **Use only for travel costs of permanent and part-time employees assigned to the program**. This includes cost for mileage, per diem, lodging, lease vehicles, registration fees and approved seminars or conferences and other approved travel costs incurred by the employees (as listed under the Salary and Wages category) for conducting the program. **Specific detail should be stated in the space provided on the Cost Detail Schedule (DCH-0386) if the Travel category (line 3) exceeds 10% of the Total Expenditures (line 10).** Travel of consultants is reported under Other Expenses - as part of the Consultant Services.

N. Supplies & Materials - Enter cost of supplies & materials. This category is used for all consumable and short-term items and equipment items costing less than five thousand dollars ($5,000). This includes office supplies, computers, office furniture, printers, printing, janitorial, postage, educational supplies, medical supplies, contraceptives and vaccines, tape and gauze, education films, etc., according to the requirements of each applicable program. **Specific detail should be stated in the space provided on the Cost Detail Schedule (DCH-0386) if the Supplies and Materials category (line 4) exceeds 10% of the Total Expenditures (line 10).**

O. Contractual (Subcontracts/Subrecipients) – **Specify the subcontractor(s) working on this program in the space provided under line 5.** Specific details **must** include: 1) subcontractor(s) and/or subrecipient(s) name and address, 2) amount for each subcontractor and/or subrecipient, 3) the total amount for all subcontractor(s) and/or subrecipient(s). Multiple small subcontracts can be grouped (e.g., various worksite subcontracts). Use this category for written contracts or agreements with subrecipient organizations such as affiliates, cooperating institutions or delegate contractors when compliance with federal grant requirements is delegated (passed-through) to the subrecipient contractor.

Vendor payments such as stipends and allowances for trainees, fee-for-service or fixed-unit rate patient care, consulting fees, etc., are to be identified in the Other Expense category.

P. Equipment - Enter a description of the equipment being purchased, including number of units and the unit value, the total by type of equipment and total of all equipment. This category includes stationary and movable equipment to be used in carrying out the objectives of the program. The cost of a single unit or piece of equipment includes the necessary accessories, installation costs and any taxes. Equipment is defined to be an article of non-expendable tangible personal property having a useful life of more than one (1) year and an acquisition cost of $5,000 or more per unit. **Equipment items costing less than five thousand dollars ($5,000) each are to be included in the Supplies and Materials category. All equipment items summarized on this line must include: item description, quantity and budgeted amount and should be individually identified in the space provided(line 6). Upon completing equipment purchase, equipment must be tagged and listed on the Equipment Inventory Schedule (see Attachment B.3) and submitted to the agreement's contract manager.**

Q. Other Expenses - This category includes other allowable cost incurred for the benefit of the program. The most significant items should be specified. . Minor items may be identified by general type of cost and summarized as a single item on the Cost Detail Schedule to arrive at a total Other Expenses category. Significant groups or subcategories of costs are described as follows and should be individually identified in the space provided (line 7). **Specific detail should be stated in the space provided on the Cost Detail Schedule (DCH-0386) if the Other Expenses category (line 7) exceeds 10% of the Total Expenditures (line 10).**

1. Communication Costs - Costs of telephone, telegraph, data lines, Internet access, websites, fax, email, etc., when related directly to the operation of the program.

2. Space Costs - Costs of building space, rental and maintenance of equipment, instruments, etc., necessary for the operation of the program. If space is publicly owned, the cost may not exceed the rental of comparable space in privately owned facilities in the same general locality. Department funds may not be used to purchase a building or land.

PROGRAM BUDGET-COST DETAIL SCHEDULE (DCH-0386) FORM PREPARATION (continued)

3. Consultant or Vendor Services - These are costs for consultation services, professional fees and personnel hired on a private contracting basis related to the planning and operations of the program, or for some special aspect of the project. Travel and other costs of these consultants are to be included in this category.

4. Other - All other items purchased exclusively for the operation of the program and not previously included, patient care, fee for service, auto and building insurance, automobile and building maintenance, membership dues, fees, etc.

R. Total Direct Expenditures – Enter the sum of items 1 – 7 on line 8.

S. Indirect Costs Calculations - **Enter the allowable indirect costs for the budget.** Enter the base amount. Indirect costs can only be applied if an approved indirect costs rate has been established or an actual rate has been approved by a State of Michigan department (i.e., Michigan Department of Education) or the applicable federal cognizant agency and is accepted by the Department. Attach a current copy of the letter stating the applicable indirect costs rate. **Detail on how the indirect costs was calculated must be shown on the Cost Detail Schedule (DCH-0386)**.

T. Total Expenditures - Enter the sum of items 8 and 9 on line 10.

PROGRAM BUDGET SUMMARY

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

Use WHOLE DOLLARS Only

PROGRAM **(A)** Budget and Contracts			**DATE PREPARED**	**Page (C) 1**	**Of 2**
CONTRACTOR NAME **(D)** Michigan Agency			**BUDGET PERIOD** **(E) From:** 10/01/xx **To:** 9/30/xx		
MAILING ADDRESS (Number and Street) **(F)** 123 ABC Drive			**(G) BUDGET AGREEMENT** **ORIGINAL** **AMENDMENT ▶**	**AMENDMENT #** **1**	
CITY Acme	**STATE** MI	**ZIP CODE** 44444	**FEDERAL ID NUMBER** **(H)** 38-1234567		

(I) EXPENDITURE CATEGORY				**(K) TOTAL BUDGET** (Use Whole Dollars)
1. SALARY & WAGES	**43,000**			**43,000**
2. FRINGE BENEFITS	**11,180**			**11,180**
3. TRAVEL	**1,400**			**1,400**
4. SUPPLIES & MATERIALS	**37,000**			**37,000**
5. CONTRACTUAL (Subcontracts/Subrecipients)	**3,500**			**3,500**
6. EQUIPMENT	**5,000**			**5,000**
7. OTHER EXPENSES				
	8,000			**8,000**
8. **TOTAL DIRECT EXPENDITURES** (Sum of Lines 1-7)	**109,080**			**109,080**
9. INDIRECT COSTS: Rate #1 %				
INDIRECT COSTS: Rate #2 %				
10. TOTAL EXPENDITURES	**109,080**			**109,080**

(J) SOURCE OF FUNDS

11. FEES & COLLECTIONS	**10,000**			**10,000**
12. STATE AGREEMENT	**90,000**			**90,000**
13. LOCAL	**9,080**			**9,080**
14. FEDERAL				
15. OTHER(S)				
16. TOTAL FUNDING	**109,080**			**109,080**

DCH-0385 (E) (Rev 2-07) (W) Previous Edition Obsolete.

PROGRAM BUDGET – COST DETAIL SCHEDULE **(A)** Page 2 Of 2

View at 100% or Larger MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

Use WHOLE DOLLARS ONLY

(B) PROGRAM	**(C) BUDGET PERIOD**		**DATE PREPARED**
	From:	**To:**	
Budget and Contracts	10/01/xx	9/30/xx	7/01/xx
(E) CONTRACTOR NAME	**(F)BUDGET AGREEMENT**		**AMENDMENT #**
	ORIGINAL AMENDMENT		
Michigan Agency			

(G) 1. SALARY & WAGES POSITION DESCRIPTION	**(H)COMMENTS**	**(I) POSITIONS REQUIRED**	**(J) TOTAL SALARY**
Nurse	9 month position	1	25,000
Project Director		.5	18,000
(K) 1. TOTAL SALARY & WAGES:		1.5	$ 43,000

(L) 2. FRINGE BENEFITS (Specify)

FICA	LIFE INS.	DENTAL INS	COMPOSITE RATE
UNEMPLOY INS.	VISION INS.	WORK COMP	AMOUNT 26%
RETIREMENT	HEARING INS.		
HOSPITAL INS.	OTHER (specify) _____		

2. TOTAL FRINGE BENEFITS: $ 11,180

(M) 3. TRAVEL (Specify if category exceeds 10% of Total Expenditures)

Conference registration **$350**
Airfare $600
Hotel accommodations and per diem for 4 days $450

3. TOTAL TRAVEL: $ 1,400

(N) 4. SUPPLIES & MATERIALS (Specify if category exceeds 10% of Total Expenditures)

Office Supplies 2,000
Medical supplies 35,000

4. TOTAL SUPPLIES & MATERIALS: $ 37,000

(O) 5. CONTRACTUAL (Specify Subcontracts/Subrecipients)

Subcontractor Name	Address	Amount
ACME Evaluation Services	555 Walnut, Lansing, MI 48933	$ 2,000
Subrecipient Name		
Health Care Partners	333 Kalamazoo, Lansing, MI 48933	$ 1,500

5. TOTAL CONTRACTUAL: $ 3,500

(P) 6. EQUIPMENT (Specify items)

Microscope $5,000

6. TOTAL EQUIPMENT: $ 5,000

(Q) 7. OTHER EXPENSES (Specify if category exceeds 10% of Total Expenditures)

Communication Costs $2,400
Space Costs $3,600
Consultant or Vendor: John Doe, Evaluator, 100 Main, E. Lansing $2,000

7. TOTAL OTHER: $ 8,000

(R) 8. TOTAL DIRECT EXPENDITURES (Sum of Totals 1-7)	$ 109,080
(S) 9. INDIRECT COSTS CALCULATIONS	$ 0
Rate #1: Base $0 X Rate 0.0000	$ 0
Rate #2: Base $0 X Rate 0.0000 % Total	$ 0
9. TOTAL INDIRECT EXPENDITURES:	
(T) 10. TOTAL EXPENDITURES (Sum of lines 8-9)	$ **109,080**

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

CONTRACT MANAGEMENT SECTION

EQUIPMENT INVENTORY SCHEDULE

Please list equipment items that were purchased during the grant agreement period as specified in the grant agreement budget, Attachment B.2. Provide as much information about each piece as possible, including quantity, item name, item specifications: *make, model,* etc. Equipment is defined to be an article of non-expendable tangible personal property having a useful life of more than one (1) year and an acquisition cost of $5,000 or more per unit. Please complete and forward this form to the MDCH contract manager with the final progress report.

Contractor Name: Michigan Agency Contract #: 2009000 Date: 10/31/08

Quantity	Item Name	Item Specification	Tag Number	Purchase Price
1	**LW Scientific M5 Labscope**	• Binocular • Trinocular with C-mount or eye tube • 35mm and digital camera adapters available • Diopter adjustment • Inclined 30 degrees (45 degrees available), rotates 360 degrees • 10X/20 high point eyepieces • Interpupillary distance range 50-75mm	N0938438EW098	$ 5,000
				$
				$
				$
				$
				$
				$
			Total	$ 5,000

Contractor's Signature: _____ Date: _____

Attachment K

Budget Narrative Instructions

All proposals must include a budget narrative and a line-item budget for the project for the timeframe April 1 2009 -- September 30, 2009.

This attachment details information required in the budget narrative. In the budget narrative, applicants are expected to justify the total cost of the program and to list other sources of funding that contribute to the CAHC program.

Budget Justification. The budget justification must provide detailed descriptions of planned expenditures, including justification and rationale. All budget line items must be described in the budget narrative**.**

- *Salaries and Wages (personnel)* - For each staff position associated with the program provide their name, title, annual salary and percent of a full time equivalent (FTE) dedicated to the program. Describe the role of each staff person in achieving proposed program objectives. Salaries and wages for program supervision are allowable costs, proportionate to the time allocated to the proposed program.

- *Taxes and Fringe Benefits* - Indicate, by percentage of total salary, payroll and fringe rate (e.g. FICA, retirement, medical, etc.).

- *Travel* - Describe who is traveling and for what purpose. Include reimbursement rates for mileage, lodging and meals. Indicate how many miles, overnights, etc. will be supported annually. **Travel of consultants should not be included in this category but rather under the category of Other - Consultant Fees.** International travel cannot be supported with funding awarded under this RFP. Out of state travel must be reasonable and necessary to the achievement of proposed goals and objectives. Staff travel for training and skills enhancement should be included here and justified. *For planning grant proposals, please refer to pages 21 and 23 of this application guidance for required trainings in Michigan that must be reflected in the proposed budget.*

- *Supplies and Materials - Describe* the types and amount of supplies and materials that will be purchased. Include justification for level of support requested for items and how it relates to the proposed program. Items requested may include but are not limited to: postage, office supplies, screening devices, prevention materials, training supplies, postage, and audio/visual equipment (under $5,000).

- *Contractual* - Describe all subcontracts with other agencies. Include the purpose of the contract, method of selection and amount of the sub-contract. Contracts with *individuals* should be included in the *Other category as Consultant Fees.*

- *Equipment* - This category includes stationary and moveable equipment to be used in carrying-out the objectives of the program. Equipment items costing less than five thousand dollars ($5,000) each are to be included in the Supplies and Materials category.

- *Other Expenses* - This category includes all other allowable costs. Common expenditures in this category include the following, though your budget may include additional items.

    - ✓ *Consultant Services* - Provide the name (if known), hourly rate, scope of service and method of selection for each consultant to be supported. The expertise and credentials of consultants should

be described. Provide rationale for use of consultant for specified services. Travel and other costs of these consultants are to be included in this category and justified.

- ✓ *Space* - Include items such as rent and utilities in this category. Each of these costs must be described. The description must address the cost per month and indicate the method of calculating the cost. Cost for acquisition and/or construction of property are not allowable costs under this RFP.

- ✓ *Communications* - Describe monthly costs associated with the following:
  - phone (average cost per month, proportionate to proposed program)
  - fax (average cost per month, proportionate to proposed program)
  - internet access/email service (average cost per month, proportionate to proposed program
  - teleconferencing (number of sessions, cost average cost per use)

- ✓ *Printing and copying* - Describe costs associated with reproduction of educational and promotional materials (manuals, course hand-outs, pamphlets, posters, etc.). Do not include copying costs associated with routine office activities.

- ✓ *Indirect Costs* - Indirect costs are not allowed under this grant.

- ✓ *Architectural Costs* – Architectural and building costs are not allowed.

- ✓ *Capitol Costs* – Capital costs are not allowed.

Other Funding Sources. If the applicant receives other funding to conduct services which are linked to the proposed program they are to supply the following information for each source.

- Source of funding
- Project period
- Annual amount of award
- Target population
- Brief description of intervention (2-3 sentences)

If applicant does not receive any other support for proposed service, indicate that this section is not applicable.